United States Court of Appeals for the Second Circuit

JOINT APPENDIX

76-7295

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United States Court of Appeals

FOR THE SECOND CIRCUIT

FOR THE SECOND CIRCUIT

CARL A. BEAZER, *et al.*,
Plaintiffs-Appellees-Cross-Appellants,

—against—

NEW YORK CITY TRANSIT AUTHORITY, *et al.*,
Defendants-Appellants-Cross-Appellees.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE
SOUTHERN DISTRICT OF NEW YORK

JOINT APPENDIX

Volume IV — Pages 1145a–1996a

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Thomas J. Doyle, M. D.
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STATEMENT OF THOMAS J. DOYLE, M.D.

Assistant Vice President and Chief Medical Director of Consolidated Edison Company

I have been Assistant Vice President and Chief Medical Director of the Consolidated Edison Company for 1-½ years and was Executive Medical Director five years prior to this. At the current time, I also serve as President of the New York State Society of Industrial Medicine. I have been responsible in large measure for the formulation of Medical Standards for employment with Con Edison, and I am thoroughly familiar with the present policy of the Company with respect to the hiring of persons with a history of drug addiction, including persons who are maintained on methadone.

Briefly stated, the policy is that Con Edison will provide employment consideration only for those ex-addicts who have been proven clean and stable in treatment for a minimum period of one year of active participation in a recognized comprehensive treatment program and have achieved medical, psychological and sociological stability, to a degree acceptable to our own standards, provided that the person also meets all other requirements for the job.

In implementing that policy, I have worked with Ms. Eileen Wolkstein, Director of Vocational Rehabilitation of the Beth Israel Methadone Maintenance Treatment Program, and Dr. Vincent Dole of the Rockefeller University. Ms. Wolkstein has provided applicants to me with written background information designed to assist me to assess the stability and employability of Beth Israel Methadone Program participants who apply for jobs with Con Edison. Thus, she has provided me with information as to an individual's job readiness.

I require the program to provide evidence of medical, psychological and sociological stability, I require evidence of good general physical and mental health without significant sequella from previous drug abuse.

This includes written documentation, confirmed by urine examination, that the applicant remained drug free for a minimum of one year. If a MMTP, only methadone is permitted.

Active participation in a competent counselling program and a written report of a comprehensive psychiatric evaluation is also required. Any history of significant behavioral or characterlogical disorder or history of psychosis is disqualifying.

Written report of the observations of a competent and trained counselor must document sociological stability. This may be evidenced by attitudinal and behavioral changes seen in relation to employment, community, family, religion, associates, etc., that demonstrate evidence to suggest the applicant would become a satisfactory employment risk.

Decision on acceptability is my responsibility - not relegated to MMTP. They provide me with candidates for employment and all the information on them necessary to make my decisions. The records and recommendations are reviewed and candidates are examined in my Medical Department; if satisfactory are referred for consideration of the Personnel Department and are required to meet all other requirements of the job for.which they are applying.

Former addicts are initially placed in trainee or non-sensitive entry level jobs, i.e. clerical and general utility man positions. Their continued stability is insured by follow-up in the medical department by administrative physicians. Periodic unannounced observed urine checks are required on demand. Other than being followed by the medical department, these employees are not singled out for special supervision by the operating department in which they work once they pass the on-trial period. I require periodic reports from their treatment program, informal and/or formal as needed to insure continued participation as individually required.

Employees hired pursuant to this policy remain within the normal promotional lines and are advanced solely on the basis of their individually demonstrated job performance and skills. The sole exception to the general policy of individual consideration is that former addicts hired pursuant to this policy are forever absolutely excluded from work in Con Edison's nuclear facility in accordance with our understanding of A.E.C. requirements. These former addicts are eligible for promotion, and have in fact advanced to a variety of operating positions outside of the entry level general utility man position. Con Edison job positions for which former addicts may qualify in the course of working their way through the normal promotional lines on the basis of individually demonstrated job performance may be complex.

Approximately (100) former drug abusers have been hired by Con Edison pursuant to the policy described above. Of those, few from MMTP's have dropped out or been terminated from the program. No accidents traceable to current drug abuse or past history of addiction have resulted from the actions of any of the study group employees who met the current criteria. A number of these employees have successfully advanced beyond the entry level positions and are satisfactorily performing in a variety of jobs.

In contrast to this experience we have firmly established to our satisfaction that approximately (100) other employees who did not meet current employment criteria had to be released because of drug related problems. Problems with lateness, absence, abnormal mood and behavior at work, poor work performance, accidents, theft, pushing drugs, using drugs at work, hospitalization for hepatitis and other drug related illness, mental breakdown, suicide and death by overdose proved this group to be a terrible employment risk. Our experience has firmly convinced us that rehabilitation of the addict requires a comprehensive and competent treatment program. Basically we do not believe that active drug abusers can or should be rehabilitated in our sensitive work environment. The responsibility, we feel, is with outside agencies.

When he has the best of both worlds the stimulus to modify behavior appears inadequate in most cases. When life style adjustments are made with 100% committment of the individual through the guidance of good programs, our experience has been excellent.

In our original study when applicants met our standards of proven stable rehabililitation, our success rate exceeded 65% over a two year period. It should be noted however that less than 5% of those who were terminated were released because of recurrent drug abuse. While our standards for employment apply equally to drug free and methadone maintenance programs. Our experience with the latter has been superior.

Beyond this generalized experience, specific data exists with respect to 13 former addicts in treatment at the Beth Israel Methadone Maintenance Program who were hired by Con Ed

As part of my duties as Chairman of the Drug Abuse Committee of the New York State Society of Industrial Medicine, I cooperated with Dr. Vincent Dole of the Rockefeller University and Ms. Eileen Wolkstein of the Beth Israel Methadone Maintenance Treatment Program in an evaluation of the job performance of these 13 individuals who have worked for Con Edison for periods ranging from 6 months to 3 years. Briefly the results of this evaluation were that in every case the employee's supervisor reported that the employee was performing as well as or better than the average Con Edison employee without an addiction history.

The policy described above with respect to the hiring of former addicts should be distinguished from Con Edison's policy with respect to the continued employment of persons who develop a drug abuse problem for the first time during the course of their Con Edison employment. These persons are required to immediately become drug free as a condition of further employment. Their adherance to this requirement is monitored through unannounced medical revisits and urine checks. Persons who are unable or unwilling to adhere to the requirements are terminated. This group, however, may be eligible for re-employment following their meeting our proof of stability criteria for a minimum of one year by participation in a recognized comprehensive competent treatment program.

In sum, while my ability to generalize about the Con Edison experience is limited both by numbers and the length of time since the implementation of our new policy, I can say that we have not thus far encountered any major problems in implementing a policy of employment of former drug abusers, including methadone maintainees, in an industrial setting.

New York, New York
October 23, 1974

Thomas J Doyle M.D.

Thomas J. Doyle, M.D.

CARL A. BEAZER, et al.,
Plaintiffs,
vs.
NEW YORK CITY TRANSIT AUTHORITY,
Defendants.

72 Civ. 5307

New York, October 25, 1974;
9.30 A.M.

Trial res

* * *

T H O M A S J. D O Y L E, called as a witness on behalf of the plaintiffs, being first duly sworn, testified as follows:

DIRECT EXAMINATION

BY MR. MORRILL:

MR. MORRILL: Your Honor, Dr. Doyle has prepared a statement which has been previously marked as Plaintiffs' Exhibit 39, and to save time I would like at this time to offer it into evidence.

THE COURT: I am going to receive it subject to any objection, just to save time. If there are any objections, we can discuss them.

(Plaintiffs' Exhibit 39 received in evidence.)

Q Dr. Doyle, I have only two questions for you on direct examination. The first is: have you found Mrs. Wolkstein at the Beth Israel Methadone Maintenance Program to be cooperative with you in furnishing you with the information needed to make an assessment of job readiness for employability of the persons that she refers to you?

MR. DUNN: Objection as to form, your Honor.

THE COURT: Overruled.

A Yes, she has been cooperative.

Q My only other question is, Dr. Doyle, do you, however, retain the right to make the final determination as to whether or not you will employ an individual referred to --

THE COURT: Of course he has. No use wasting time.

A Absolutely.

MR. MORRILL: That is all, your Honor.

THE COURT: We will adjourn now.

MR. SUMMERS: Just a few questions, your Honor.

Q Dr. Doyle, what are the specific conditions you lay down to a methadone program in order to get an acceptable employee?

A I require the program to provide evidence of medical, psychological and sociologicalstability. I --

Q What does that consist of?

A I require evidence of a good general physical and mental health condition without significant sequella from previous drug abuse.

THE COURT: Isn't that stated in the statement?

THE WITNESS: All of this is stated in my statement.

THE COURT: We won't want to have it repeated.

Q When the employee comes to you -- I haven't looked at your statement, but does your statement tell

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as what controls Con Edison employs in order to monitor?

A Yes, it does, sir.

Q Does that include urinalysis performed by Con Ed?

A Con Ed doesn't perform the urinanalysis. We have observed specimens passed in front of the administrative section and we refer these specimens for analysis to outside laboratories.

Q You do take the specimens?

A Yes.

Q How frequently?

A On your regularly scheduled bases, based on our own assessment of need.

Q What determines your assessment of need?

A Our observation in the early part of the employee's course with us are more frequently than later, once we establish to our own satisfaction that things are going well.

Q In the event you take urinanalysis and it turns out positive for drug use, what do you do?

A He is terminated.

Q You have some sort of a telephone system by which you can call employees without notice?

A Yes.

Q How do you work that?

A We notify the supervisor that we want to see such-and-such an employee in the medical department at a particular time.

Q And this is based upon some information or need that you feel to check him; right?

A I don't understand.

Q What determines whether you go to the telephone and tell the supervisor to send him?

THE COURT: Obviously if there is a problem with the man they summon him.

Q What is it that determines whether you summon him or not; what problems do you have?

A It is not a problem. It is the way we follow up a patient. We don't advise him in advance when we are going to call him, so that we call him at these irregularly unannounced periods to be certain that when we call him he won't be prepared in advance, for instance, to become clean, if he has been using, and we will be able to spotcheck and confirm to our own satisfaction that he has remained clean, and if he is on methadone, then he remains on methadone alone.

Q Have you found any dirty urines in persons you have summoned without notice to give you a specimen?

A Yes, we have.

Q And you have terminated them?

A Yes.

Q How do you find your cooperation with the program from which these patients come?

A We take our patients from a variety of programs. If you are talking about the 13 in this study group in which we cooperated with Miss Wo[illegible]in, we haven't had any dirty urines in that group. That's been a fine group.

Q It is a very select group?

A Yes, it is.

Q How long have you had them?

A Between six months and three years.

Q Are they to become regular employees?

A Yes, all of our employees become regular ones. They have been through our two-month, on-trial period. If they are acceptable to the Department learn what they are supposed to learn and they pass through the on-trial period, then they become regular employees.

Q What arrangements have you got with the program to give you information that you might feel you need at any time?

A I telephone and ask for the information or I ask the patient to have the counselor drop me a note confirming such and such. I do it on that basis.

Q Is there any information you have ever asked for which has been refused for any reason?

A No.

Q Have you ever asked the program for the latest urinalysis that the program has on this individual?

A Yes.

Q Have you ever asked the program for whether or not a patient has missed any of his prescribed medication?

A Oh, yes.

Q And they have given you that information?

A Yes, sir.

MR. SUMMERS: Okay, thank you.

(Witness excused.)

STATEMENT OF PAUL KOLISCH

Personnel Supervisor, BernzOmatic Corporation

I have agreed to appear as a witness in this case to describe my experience with the employment of rehabilitated former drug addicts at the BernzOmatic plants in Medina and Alden, New York, where I serve as Personnel Supervisor. I have been responsible for the formulation of personnel policies for these two plants, including the policy with respect to the employment of former drug addicts. I am thoroughly familiar with all of the operations carried out in these plants, including mechanical operations, training, supervision, personnel selection and safety.

BernzOmatic is one of the largest manufacturers of propane torches in the country. Until recently, there were approximately 25 employees in the Alden plant and approximately 145 in Medina. The jobs in both plants generally fall into the category of assembly line and manufacturing work. Thus, at the Alden plant, charcoal fire starters, cans and horns are assembled. In Medina, employees braze cylinders, assemble valves and build small tools.

The work at both plants is inherently quite dangerous as employees work with and around a number of heavy machines, including drill presses and punch presses. There are a number of heavy duty presses in the Medina plant including a necker and perforating punch. In the manufacture of fire extinguishers, aluminum slugs must be waxed by employees with dangerous and caustic chemicals. Proper job performance and manual dexterity are crucial for the safety of the employee and his fellow workers. In addition, there is very little or no supervision in these plants. At the Alden plant, a foreman tells employees in the morning what they are to do during the day, and they are then left virtually on their own to do it.

For a period of time now, I have hired drug-free former addicts referred to me by the Iroquois Rehabilitation Center. The program has referred approximately 9 such persons to me. I have found the program to be extremely reliable in terms of the persons it has referred to me. My experience with these employees has been very satisfactory. Their attendance records have been good, their work quality very satisfactory, and their motivation extremely high. They have gotten along very well with their colleagues. I did not attempt to supervise them any more than the usual employee or formally monitor their progress. This group of employees, to my knowledge, has produced no accidents. In short, I have found the rehabilitated former drug addicts referred to me by the Iroquois Rehabilitation Center indistinguishable from other BernzOmatic employees.

I have concluded that neither a past history of drug abuse alone, nor participation in a recognized drug-free treatment program, is a valid reason to disqualify a person from work in an industrial setting. I intend to continue to hire persons referred to my by the Iroquois Rehabilitation Center.

CARL A. BEAZER et al

-vs- 72 Civ. 5307

NEW YORK CITY TRANSIT AUTHORITY.

October 29, 1974

9:10 a.m.

— — —

[Trial resumed.]

* * *

PAUL JULIAN KOLISCH, called as a witness in behalf of the plaintiffs, after having been duly sworn, testified as follows:

DIRECT EXAMINATION

BY MR. MORRILL:

MR. MORRILL: Your Honor, the written statement of Mr. Kolisch's direct testimony has been prepared and I would like to ask that it now be marked as Plaintiffs' Exhibit next numbered in sequence.

THE COURT: All right.

[Plaintiffs' Exhibit 42 marked for

maintenance; right?

THE WITNESS: That is correct.

THE COURT: At the end of this statement you say:

"I have concluded that niether a past history of drug abuse alone nor participation in a recognized drug-free treatment program is a valid reason to disqualify a person from working in an industrial setting."

When you say " a recognized drug-free treatment program," you are not talking about a methadone maintenance program, are you?

THE WITNESS: I have never had any contact with that.

THE COURT: What is the Iroquois Rehabilitation Center? What does it do?

THE WITNESS: It is part of the drug abuse control center. It is located south of the Village of Medina. It is in the center of a game preserve.

THE COURT: Where is Medina?

THE WITNESS: Medina is about forty-five miles east of Buffalo.

THE COURT: What is the Iroquois program; do you know?

THE WITNESS: It is a rehabilitation program where they work on the game preserve. They have classes at the center in academic and vocational areas.

THE COURT: They have what at the center?

THE WITNESS: Classes, both academic and vocational.

THE COURT: Do you know how they proceed as far as getting people drug-free? Do they help them get to be drug-free or do they take them after they are drug-free? What do they do? Do you know?

THE WITNESS: Not entirely, no.

THE COURT: You don't know much about that?

THE WITNESS: Not as far as the actual drug-free operation.

THE COURT: Is there any cross?

CROSS-EXAMINATION

BY MR. DUNN:

Q Mr. Kolisch, when did you prepare this statement?

A I prepared it in conjunction with Mr. Morrill last week.

Q Did you dictate the statement?

A No, not as such.

Q Can you tell me how it was prepared?

A We discussed the matter over the phone and I received a precis of my position and we got together on the telephone again and clarified it.

Q When did you see the statement in its final form for the first time?

A Yesterday.

Q That was presented to you by whom?

A Mr. Morrill.

Q In your statement, Mr. Kolisch, you state that the program, the Iroquois Rehabilitation Center, referred approximately nine such persons to you. Can you be more precise as to how many persons had been referred to you by the Iroquois Rehabilitation Center?

A People that I have actually hired, nine.

Q How many have been referred to you that you did not hire?

A I'm always told how many people are available for my purposes by the Iroquois people. I suppose that would be a reference, but, in fact, we have not done a great deal of hiring the past year, so I couldn't hire everyone that was referred. I haven't turned anyone down.

Q What do you know about these persons that are referred to you so far as their drug history?

A I know very little about their drug history. I know that they are drug-free.

Q How do you know that?

A By what I'm told by the directors and employment people at Iroquois. I don't know further than that. I know that they have had a successful work record at the Iroquois Center and at what are called secondary jobs in the area.

Q For how long a period of time have these people been drug-free?

A I don't know.

Q How long a period of time have these persons been addicted to drugs?

A I don't know.

Q What drugs have these persons been addicted to ?

A It is my understanding that some of them --

Q Do you know?

A I know that some of them had been addicted to heroin.

Q How do you know that, sir?

A This is what I was told by the directors of the facility.

Q Do you perform any independent investigation or independent study of these persons or evaluation of these persons?

A We evaluate all our employees.

Q Of the nine persons that you hired, when was the first one hired?

A I believe it was the beginning of November 1973.

Q Is that person still with you?

A No, sir.

Q Would you tell me in what capacity the person was hired?

A He was hired to work in Department 89, which embraces cylinders and performs other sub-assemblies.

THE COURT: What was he specifically hired to do in that department?

THE WITNESS: Well, in that department you must do anything you are told by the foreman. I know that he at times unloaded the furnace. He ran drill presses. He did rework.

THE COURT: Did he do any brazing?

THE WITNESS: Well, the brazing is an automatic process in large ovens, but he would be around those ovens constantly.

Q What were his hours of work, sir?

A He was on the midnight shift. It would be 10:30 in the evening until seven in the morning.

Q What was his name, sir?

A Horst Larrabbee.

Q How long did he remain in your firm's employment?

A I can't remember. It was several months until he was offered a better paying job at another factory for which I recommended him.

Q With the same firm?

A No, another company.

Q When was the second employee hired?

A Within a day or two of that one.

Q What was his position?

A He also worked in Department 89, the same sort of work.

Q Is he still employed?

A No, he isn't. He is, I believe, on after-care. I don't think he is at the center.

Q Is he still employed by your firm?

A No, sir, he has moved on.

THE COURT: What do you mean, moved on? What is he doing?

THE WITNESS: He went on to another local company in Medina and then, when people from Iroquois want after-care, they have to leave the whole area of Medina. They cannot stay in the Medina area, so I don't know where he went.

THE COURT: He wasn't fired by you?

THE WITNESS: No.

THE COURT: He left voluntarily for a better job?

THE WITNESS: Yes.

Q How long a period of time was he employed?

A I can't remember. I believe about three months or so.

Q How long a period of time was the first person that you referred to employed?

A About the same time, three or four months.

Q When was the third employee hired?

A I can't remember, sir.

Q Do you remember his name?

A I believe it was Orlando Mecado, but I'm not certain.

Q Is he still with your firm?

A No, he is not.

Q Where is he?

A I don't know where he is.

Q How long was he employed?

A He was only employed for about a month.

THE COURT: Is this the third man?

THE WITNESS: I think it may have been. I'm not sure.

THE COURT: He was one of the men; right?

THE WITNESS: Yes.

Q When was the fourth man hired, sir?

A I don't remember.

Q Do you recall his name?

A I can recall the names of the employees, but I can't remember the order in which they were hired. It may have been Jeff MacKenzie.

Q Is he still with your firm?

A No, he is not.

Q How long was he employed?

A MacKenzie was there for about two months, I believe.

Q What happened to Mr. MacKenzie?

A He went on to work at a fruit packaging company, I think. It is an orchard area.

Q The fifth employee, when was he hired?

A I don't remember any of the dates. I believe the next employees I hired were at the Alden facility, and I just do not remember exactly when they were.

THE COURT: This should have been in the statement. This is very superficial and general. It is just wasting time to have to probe this. You have nine people and you should have the names, the dates, their history, everything about them. This has a lot of general information, which is just worthless to me. and just takes up a lot of time. If it wasn't in the statement he should have brought his records down here.

We'll do the best we can.

Tell us, were these people all doing the same kind of work?

THE WITNESS: In Medina, by and large, yes, sir.

THE COURT: How many of the nine were working at these ovens and drill presses?

THE WITNESS: Six.

THE COURT: What were the other three doing?

THE WITNESS: They were working in another department where they have hand tool assembly and fire extinguisher filling. One of the men was running the filling machine and crimping machine for fire extinguishers. Another one, I believe, spent most of his time doing sub-assemblies on the fire detector and the third man also worked in the fire extinguisher department.

THE COURT: Were any of these men there more than three or four months?

THE WITNESS: Not in Medina, no, but in another plant. I have one in Alden. The man is still with us, in fact.

THE COURT: How long has he been with you?

THE WITNESS: I believe it is about five or six months now.

THE COURT: He is the only one still there?

THE WITNESS: Yes.

THE COURT: And he is in the Alden plant?

THE WITNESS: Yes.

THE COURT: What has he been doing, again?

THE WITNESS: He has been waxing slugs for the presses there and making charcoal fire starter.

THE COURT: Were any of the other eight terminated involuntarily?

THE WITNESS: Yes.

THE COURT: How many of them were terminated involuntarily?

THE WITNESS: Orlando Mecado and Jeffrey MacKenzie both were.

THE COURT: Why were they terminated ?

THE WITNESS: They worked in an area that required quite a good deal of manual dexterity in terms of sub-assemblies. They were just not making rates, the rates required for each job.

THE COURT: To your knowledge it didn't have anything to do with a drug problem?

THE WITNESS: Absolutely not.

THE COURT: I'm sorry, Mr. Dunn.

MR. DUNN: Thank you, your Honor.

Q Do you have any experience in the field of drug rehabilitation?

A No, sir.

Q What is your present position with Bernzomatic?

A I'm the personnel supervisor in Medina and Alden.

Q To whom do you report?

A The director of Industrial Relations in Rochester.

Q How long have you been with the firm?

A I have been with the firm since August of 1973.

Q Where were you employed before that?

A The Albion Central School System.

Q When you hired each of these nine individuals for the Bernzomatic Corporation, was it your understanding that they would be permanent employees or was their employment to be a temporary thing until they reached another stage in their rehabilitation and entered what you described as after-care?

A I understood it to be of a temporary nature until they went into after-care, yes.

MR. DUNN: Thank you very much, Mr. Kolisch.

MR. MORRILL: I have just a few more questions.

THE COURT: All right.

Beazer v. New York City Transit Authority

STATEMENT OF JAMES E. PETERSEN

Director of Employee Relations, Kennecott Copper Company, Utah Copper Division

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I have agreed to appear as a witness in this case to describe my experience with the employment of former drug addicts at Kennecott Copper's Utah Copper Division.

Kennecott, a multi-national corporation, is the largest copper company in the world. The Utah Copper Division, which is the largest division of the metal mining division of Kennecott, employs some 7500 persons, almost all of whom are actively engaged in heavy duty industrial mining work.

I have worked for Kennecott for approximately the past 26 years, and have served as Director of Employee Relations for the past 16 years. As such, I am responsible for all labor relations, contract negotiations, employment policies, training, management development, administration of benefit plans, and EEOC compliance for the entire Utah Copper Division. I am thoroughly familiar with the operations of the Utah Copper Division, and have had a major role in the formulation of personnel policies, including the policy of the company with respect to employment of former drug abusers.

It is difficult in a short statement to characterize the danger and complexity of the work at the Utah Copper Division. It is extremely hazardous, heavy duty industrial work. In the mining area, employees work with and around heavy duty large mobile machinery. Some of these machines are on tracks, others move independently. In the concentrating plant, stationary ore machines grind and crush the ore which has been transported from the mining division. Also part of the Utah Copper Division is a heat plant, which includes both a smelter and a refinery, each made up of extremely hazardous equipment. It is manifest that with work as complex and hazardous as ours, the safety of an employee and his fellow workers is absolutely dependent upon proper job performance. Our safety record, of which we are proud, is testified to by the fact that while the industry-wide average of accidents is 9 to 10 accidents per million man hours worked, Kennecott's accident average has consistently been approximately 2 accidents per million man hours worked. We have found our policy with respect to the employment of former drug abusers to have had no adverse impact on this safety record.

The substance of the Utah Copper Division's policy with respect to the employment of former drug abusers is that persons who have been or are in treatment (either drug-free or methadone maintenance) or persons with a history of drug addiction who have been drug free for a period of time are wholly eligible for employment with Kennecott and may be placed in any job, and on any shift. Indeed, we no longer even ask about drug abuse on our pre-employment application form, and any person who satisfies our general requirements with respect to skills, character, education and experience is fully eligible for employment.

Persons working for the company who develop drug abuse problems are referred to an in-house counseling program on a confidential and anonymous basis. While these persons are not given any immunity from company disciplinary procedures for inadequate performance, no person is fired solely for heroin use, or, of course, for participation in a methadone maintenance treatment program. While in the program, the person is allowed to remain on the job if he is able to work. Persons who are unable to work are fully eligible for company disability benefits. The company treatment program is covered under our medical policy as are any auxiliary services that may be needed. Persons who fail to cooperate with the company counseling program may have their employment terminated. These persons, however, may be allowed to remain with the company treatment program and if they eventually succeed in their rehabilitation, they may be rehired by Kennecott and have their company seniority reinstated.

We consider the program, which covers drug addicts, alcoholics, and persons with psychiatric problems, to be highly successful, both in terms of employee stability and productivity, and from a business point of view, in reduction of costs to the company. Thus, a study of 150 employees with a variety of problems, chosen at random, which compared the medical insurance and absenteeism costs for six months prior to their entry into our program with the same costs for the six months after the release from our program, shows that the company saved $128,000.

Both employees and the labor union have been very supportive of our policy with respect to the employment of former addicts. We have found there to be absolutely no adverse impact on our safety record which has remained outstanding. Because of our success with the program, one of my employees, Mr. Otto F. Jones, has organized Human Affairs, Inc., outside of Kennecott. Human Affairs, Inc. acts on a consulting basis to help other companies establish a policy and a program similar to Kennecott's. Programs have thus far been established at United States Steel Corporation's South Chicago and Geneva Works, for Philadelphia's public employees and for the Valley Bank of Phoenix, Arizona.

In brief, Kennecott's experience with the employment of rehabilitated former drug addicts has been that they have performed as well as the population at large of workers of the Utah Copper Division. They have worked safely and competently in an extremely hazardous, very heavy industrial setting. As businessmen, we have concluded that their good and dependable performance makes their employment sensible from an economic point of view. As industrialists, we have concluded that neither a prior history of drug abuse alone nor participation in either a methadone maintenance or a drug-free treatment program is a valid reason to disqualify a person from work in a hazardous industrial setting.

CARL A. BEAZER et al

- v s - 72 Civ. 5307

NEW YORK CITY TRANSIT AUTHORITY.

October 29, 1974

9:10 a.m.

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* * *

J A M E S P E T E R S E N , called as a witness in behalf of the plaintiffs, after having been duly sworn, testified as follows:

DIRECT EXAMINATION

BY MR. MORRILL:

MR. MORRILL: Your Honor, a written statement has been prepared. I would like to ask that this be marked as Plaintiffs' Exhibit next in sequence.

[Plaintiffs' Exhibit 43 marked for identification.]

Q Mr. Petersen, have you examined the Plaintiffs' Exhibit which was just marked?

A I have.

Q Is that your statement?

A Yes, sir, it is.

Q Do you adopt that statement as your direct testimony in this case?

A Yes, I do.

Q Could you describe for the Court the process by which this statement was prepared going back chronologically to the first time you spoke to me and the number of times you have spoken to me since?

A The beginning of the statement started when you called me on the telephone in Salt Lake City; and I described our program to you over the telephone. It was subsequently made accurate upon my arrival in New York, having met with you last evening.

Q I have just a few questions for you on direct examination, Mr. Petersen. Do you know approximately the numbers of former drug abusers that have been referred to your in-house counseling program?

THE COURT: Let's introduce the statement now so I can see it.

MR. MORRILL: I'm sorry. I would move that the statement be received in evidence.

[Plaintiffs' Exhibit 43 received in evidence.]

THE COURT: Give me just one second.

[Pause.]

Q Mr. Petersen, I had asked you if you knew the number of persons with drug problems who had been referred to your in-house counseling and referral program.

A Yes, I do. In the little more than four years we have had this program in operation, 130 employees have been placed by Insight, which is the name of our program, into rehabilitation.

THE COURT: What was the number -- 130?

THE WITNESS: Yes, 130.

THE COURT: Over what period of time?

THE WITNESS: Since July 1 of 1970, the day we started the program.

Q Do these 130 people represent persons who have come to the program on a voluntary basis?

A Yes.

Q Mr. Petersen, what are the hours of operation of your business?

A We operate seven days a week, 24 hours a day.

Q Do you place any limit on the shift on which a person with a drug abuse problem can work?

A No, we do not.

Q Would they then be allowed to work on the night shift?

A Yes, they would.

Q Mr. Petersen, you say in your statement that you do not ask about drug abuse in your pre-employment application.

A No, we do not. It is not on our form.

Q What is the criteria for determining whether a person should be hired? What is the principal criteria?

A If he is currently free of drug abuse, and if he can meet the qualifications of the job.

Q What is the standard, the principal standard for retention in the employ of Kennecott?

A Adequate performance.

MR. MORRILL: I have no further questions on direct.

THE COURT: You say you don't ask about drug history of someone applying; right?

THE WITNESS: We do not.

THE COURT: But you do require information as to whether they are presently on drugs?

THE WITNESS: No, we do not.

THE COURT: Where is it covered in the statement?

MR. MORRILL: On Page 3, your Honor, the top of the page.

THE COURT: I thought you said that one of the conditions for employment was that he was drug-free. I thought you just said that.

THE WITNESS: May I explain?

THE COURT: All right.

THE WITNESS: About the only question we have on the application form, other than the normal type of application form, is whether or not a person has been found guilty of a crime. We ask no questions about drugs. We have a number of doctors who give physical examinations to prospective people looking for employment. Should they find needle marks, they then inquire. If they find that the person is actively on drugs, we wouldn't hire him.

On the other hand, if they determine -- and I checked with our doctors before I left home -- if they determine they are drug-free, we hire them.

THE COURT: I take it if they were on a methadone program you would consider hiring them?

THE WITNESS: Yes, we would.

THE COURT: But if you had an active heroin addict who was not being rehabilitated, you wouldn't hire him?

THE WITNESS: No, we wouldn't.

THE COURT: You may cross-examine.

CROSS-EXAMINATION

BY MR. DUNN:

Q Mr. Petersen, you testified that in the past four years 130 persons have been referred to the counseling service by Insight; is that correct?

A The counseling service is Insight.

THE COURT: You used the word Insight and --

MR. DUNN: The witness used that on direct examination, your Honor.

THE WITNESS: But our counseling service is called Insight. In other words, Insight does not refer to a counseling service. Insight is the counseling service.

Q Is it correct that 130 persons were counseled by the service in the last four years?

A Yes, sir.

Q How many of these were drug addicts, persons presently taking drugs?

A 130.

Q They were all drug addicts?

A Yes.

Q How many were taking methadone?

A I don't really know how many were taking methadone.

Q What rate of success does the counseling service have?

A We don't know how to measure success.

Q Of the 130 persons, some were counseled by the service. How many are still in your employ?

A I'd say about 125.

Q How many of these are on methadone maintenance treatment programs?

A I don't know.

Q Who would know?

A Mr. Jones who runs our Insight program.

Q Did you discuss this with Mr. Jones before coming to New York?

A Yes, I did.

Q How many persons have you in the last four years hired knowing that these persons were members of the methadone maintenance treatment program?

A I don't know.

Q Any?

A I don't know that either.

Q Who would know?

A I don't know that anybody knows other than to poll our doctors that give the physical examinations for our employees. We wouldn't know if somebody was on methadone when we hired them. If our doctors found out, no cause to question.

Q Does your Medical Department conduct a urinalysis?

A Not for drugs, we do not. We considered that and decided against it.

Q Do you know what percentage of the population in the area in which Kennecott Copper, the Utah Copper Division operates, what percentage of the population is being treated for drug abuse?

A I don't know.

THE COURT: Where is your operation actually? Where is this mine?

THE WITNESS: The Utah Copper Division is located about 25 miles southwest of Salt Lake City, Utah.

THE COURT: Is it one large mine or is it a series of mines or is it an area? I just want to get some picture of what you are talking about.

THE WITNESS: I will describe it. The greater Salt Lake City area takes in Salt Lake County and South Davis County. That is considered the greater Salt Lake City area. It has about 500,000 people, a population of 550,000 people.

The Utah Copper Division operation is located about 25 miles southwest of Downtown Salt Lake City.

The Utah Copper Division consists of four major plants. One is a huge open pit copper mine. The material is drilled, blasted and transported from the mine about 15 miles to some concentrator, some mills. The end product of that goes to a smelter about four miles from the concentrators. The anodes that are produced at the smelter are then transported a couple of miles to an electrolytic refinery. It takes about 7,500 people to run that operation.

THE COURT: So of the four facilities you have described is mine first and the mills second and the smelter third and the refinery fourth?

THE WITNESS: Right.

THE COURT: And you have 7500 total employees?

THE WITNESS: Right.

THE COURT: Go ahead.

BY MR. DUNN:

Q Exactly how do your duties tie in with the rehabilitation program at Kennecot?

A I am the employee relations director for the Utah Copper Division. The Insight concept was my program. I hired the MSW, a master of social work, psychiatric social worker, his name is Otto Jones. He is the fellow who runs our Insight program.

THE COURT: What's his name?

THE WITNESS: Otto Jones.

The concept differs from most company concepts, because we run what we call a Troubled People Program. In the Salt Lake area there are about 220 community service agencies. The Kennecot family in Utah consists of about a total of 28,000 people, counting employees and dependents. Those people have all kinds of problems, like any other population of 28,000 people.

And the concept is that any of our employees or dependents who have a problem of any kind can voluntarily come to our program and solicit help and then our organization ameks it its business to learn about the viability of community resources and we act as a referral agency.

Now, in the time that we have had this program going, 130 employees on a voluntary basis have come to the Insight Program for help with various types of drug abuse problems, and in that same period of time, about 120 dependents have come to our service to secure help with drug abuse problems.

The program is completely voluntary and it's guaranteed confidential.

Now, so, my specific reply to your question is, I'm the boss of the guy who runs the program.

Q When you say, Mr. Petersen, that it's strictly confidential, what do you mean by that?

A Well, I mean that I don't know anyone of those 130 employees who have come to Insight to get help. I couldn't name you one of them.

Q Do you know what help has been offered to them?

A Yes. We make most of our referrals to the psychiatric community for drug abuse. Although we have utilized Odyssey House and the Manhattan Project and the

Project Reality which is a methadone treatment center.

THE COURT: Where is Project Reality?

THE WITNESS: In Salt Lake City.

THE COURT: Where is Odyssey House?

THE WITNESS: In Salt Lake City.

THE COURT: What is Odyssey House?

THE WITNESS: As I understand it, Odyssey House is a quit cold heroin treatment method that originated in New York City, and has subsequently spread to other parts of the country.

THE COURT: When you say "quit cold" what do you mean?

THE WITNESS: Well, I don't know much about drugs, but "quit cold" is just come off heroin and make it the hard way, you don't use substitutes to help you come off it.

THE COURT: And then Project Reality is what?

THE WITNESS: Project Reality is a methadone treatment center.

THE COURT: I have a little trouble getting from this the specifics that I think I need, Mr. Petersen, and maybe it's here but I just read it too quickly.

Now, I want to try to focus, see what specifically have been people with heroin problems.

Now, you have said that since your program started, 130 people employed by Kennecot have been referred to your counseling service.

THE WITNESS: Have come voluntarily for help.

THE COURT: Have come in voluntarily and have been referred to the counseling service for some kind of drug problems, right?

THE WITNESS: Right.

THE COURT: And you are not sure how many of those have related to heroin, right?

THE WITNESS: No, I am sure. I know.

THE COURT: About how many?

THE WITNESS: Seven, precisely. We have had seven heroin cases that have related to your employees coming in voluntarily?

THE WITNESS: That's right.

THE COURT: Now, do you know what was done with those heroin cases; were they sent to Odyssey House, were they sent to Project Reality, or what was done with them to try to help them?

THE WITNESS: Well, to the best of my knowledge, six of those seven have made it; in other words, they are no longer using heroin, and they are still our employees.

Now, I can't tell you to whom those six were referred.

THE COURT: When you say were aided.

THE WITNESS: I mean they are not on heroin -- they are now drug free.

THE COURT: Completely drug free?

THE WITNESS: To the best of my knowledge they are completely drug free, this is the information that Mr. Jones gives me.

One of those fellows --

THE COURT: Not on methadone or anything else?

THE WITNESS: On nothing. One of those fellows has left the company, we don't know what has happened to him, we don't know whether he is now drug free or whether he is still on drugs.

THE COURT: Do you know of any cases in addition to those seven which have come to the attention of your department, for let's say involuntary reasons, somebody observes slack work or something like that, do you know what I mean?

THE WITNESS: Yes, I do.

THE COURT: Do you know of any cases like that?

THE WITNESS: No, I do not.

THE COURT: Now, the other category I can think of are people applying for work at Kennecot.

Do you know of any person applying for work at Kennecot where, for one reason or another, it has been revealed that he at that time was on heroin or on methadone?

THE WITNESS: I can't answer that question specifically, but I can relate to you the conversation I had with our doctors on that subject the day before I left Salt Lake City.

THE COURT: Okay, tell me about it.

THE WITNESS: All right.

First of all, there are very few people looking for employment who show needle marks. In terms of percentages, less than one percent, according to our doctors.

If our doctors have reason to believe as a result of seeing needle marks that this person might be a drug addict, he will inquire of the fellow, and if he continues to have reason that he may be utilizing drugs, we will not hire him.

On the other hand, if this fellow tells him that he has been rehabilitated or is being rehabilitated, our doctors tell me that they then make inquiry of the location where this fellow is supposed to have sought and received rehabilitation and if he is rehabilitated, we will hire.

THE COURT: Well, do you have any specific information about what has happened under that policy? I guess maybe the answer is no and you have already told me, but let me ask you again.

Do you have any specific information about individual cases, or numbers of persons where needle marks have been discovered and where they have been hired because they are participating in some rehabilitation program?

THE WITNESS: I do not.

THE COURT: Okay.

Now let's get back to the seven that we talked about earlier.

Do you have any specific information about what kind of jobs they were doing for Kennecot?

THE WITNESS: I do not have specific information, but I can describe the types of jobs that are in Kennecot.

THE COURT: Yes, but I am wondering, were there people -- were any of these people -- wait a minute.

Do you have any specific information about what jobs at Kennecot these seven actually had?

THE WITNESS: I cannot. But this may be of value. The jobs that people have in Kennecot are controlled by seniority and people automatically go to those jobs unless the company can prove that the guy is not qualified to perform that job. We have 19 different labor unions in the Utah Copper Division, and jobs on the line promotion from the entry job to the top job and the union jurisdiction is controlled entirely by seniority.

Now, that's all in my responsibility, and I know of no case where -- and I would know if it had happened -- I know of no case where any employee has been denied a job promotion opportunity as the result of having used drugs of any kind.

THE COURT: Would you be able to tell me anything about your -- what was the purpose -- how did it happen that Kennecot developed a policy which is obviously different from other employers? What was it? Was it a humanitarian, was it a religious purpose, was it economics? Could you explain that a little bit?

THE WITNESS: Yes, sir, and I can say it is a combination of those things.

In the late '60s, I went to the fellow I worked for, the general manager of the Utah Copper Division with a lot of statistics with respect to the impact of alcoholism on job performance, highway deaths, mental institutions, absenteeism, that had been developed by the National Counsel of Alcoholism, and told him that I would like to develop for the Utah Division of Kennecot Alcoholic Rehabilitation Program. He gave me carte blanc to do it. I had a young lawyer on my staff that I assigned to carry out this responsibility. He barely got started and he was proslighted.

THE COURT: What do you mean he was proslighted?

THE WITNESS: He was hired away from us by a very smart sugar company. They got a good man.

THE COURT: Go ahead.

A I came to New York City to talk to the National Council of Alcoholism, and asked them if they knew of companies who had good programs, because we were prepared to go steal one from some successful program. And they gave me the names of several companies. And I did visit one of those companies, and I came away very disappointed because it was obvious from the number of people, the length of time -- it was a heavy duty industry, the length of time of the program and the numbers of people that they had placed in alcoholic rehabilitation, that their rate of penetration was very shallow, and I thought it was an underrated program.

THE COURT: What do you mean, "rate of penetration?"

THE WITNESS: Well, the NCA claims that in the heavy duty industry like copper or steel, that as high as eight percent of your entire population can be some place in the continuum of alcoholism. The company that I visited had barely scratched the surface, in a period of about eight years, they had not placed one percent of their people in alcoholic rehabilitation, and the age of their discovered alcoholic was about 55. To me that was not good enough performance.

So, subsequently, I hired this MSW, Otto Jones, and every time we'd hear of a good program, I'd send Otto Jones to investigate. At every place he went we learned the same thing, there was no penetration into the problem, and we began then to think in terms of, well, what about the drug scene; should we have one program for alcoholics, another for drug addicts? What about the people who have familial problems, marital problems, death problems, legal problems, psychosomatic problems, and we came up with this very simple concept of a troubled people program that I have tried to describe previously in my testimony. That's how it came about.

THE COURT: How it came about, but my question was a little something in addition to that. Maybe you can't define it very well, but I asked you what was the underlying motivation, if you can tell me; was it a humanitarian, or religious purpose, or was it belief it was sound business economics or was it all of those or what, can you explain that a little bit?

THE WITNESS: I think it is a combination of two things. One, it is a combination of feeling, of social betterment for our people, and I also felt from the beginning, and I think subsequently we have proved it, that we save money. The average age of the Kennecot alcoholic, for example, in our program is 34. That's 20 years ahead of discovery, the great alcoholic program in this country. And we conducted some research. In this whole field, your Honor, there is no -- nobody has ever developed either definitions or methods of measurement in terms of how long must an alcoholic remain sober before you put a success mark in the book? Those kinds of things have never been developed in this whole area.

We took a group of 37 people that we knew drank very heavily and we measured their cost in terms of absence from the job, what they cost us under our hospital medical surgical program, what they cost us under our non-occupational illness and accident program, and we learned that the alcoholic was absent from the job seven times more than the non-alcoholic, that is, than the average of all of our employees, that their hospital medical surgical costs ran nearly four to one, and we have a very expensive HMS program, and that their weekly indemnity or non-industrial accident and illness insurance clause also ran about four to one, and using that as a threshhold, we started building this program.

After the program had been in effect long enough that we could do some measuring -- and we only know how to measure certain types of things -- we took 150 people at random, employees, and by random, I mean people who had been in the program and out of the program, irrespective of why they were in the program, and again, we measured for a six-month period before their involvement, we measured their absenteeism, we measured their hospital medical surgical costs, we measured their weekly indemnity costs, and then we took a six-month period after release from this program, and measured the same things.

Now, work attendance for this group improved 53 percent, their HMS costs were cut 55.3 percent, and their weekly indemnity costs were cut 74.6 percent, and that equates to to annual saving for those 150 people, or to a less expense for those 150 people, of $128,000 a year.

So, we think the program pays dividends. My personal opinion is that we have made a breakthrough in mental health for our people.

THE COURT: Is Kennecot the biggest employer in the State of Utah?

THE WITNESS: It is.

THE COURT: And you took the 28,000 employees and their dependents, have you estimated the number of people those would be?

THE WITNESS: What percentage of population?

THE COURT: No, of the 28,000 employees in the State of Utah.

THE WITNESS: We have 7500 employees, and they have so many dependents.

THE COURT: The total you estimate at 28,000?

THE WITNESS: Yes.

THE COURT: Now, let me ask, if I could interrupt this a minute -- it is a little after 10 o'clock. The criminal case that I had thought would go to trial, I am advised that both defendants intend to plead guilty, so that brings me up -- if they do plead guilty, that frees me up today and tomorrow.

I have a short conference in another case and I would like to recess now briefly to attend to these other matters and see what you can suggest about using the next two days to the best advantage. Obviously, I wouldn't expect you to be prepared to go through today, but if you can, if we can collect ourselves and reconvene as soon as possible to get the case taken care of, it is a great opportunity.

Have you got any further cross for him or can you release him?

MR. DUNN: I do have more, and I don't think the schedule is going to be upset by waiting until after. Do I understand we are going to resume after?

THE COURT: I need about 20 minutes to take care of a couple of other things. Probably I ought to do that now.

How much cross do you have of this?

MR. DUNN: It may be fairly extensive. I prefer, with your Honor's permission, to wait until after we reconvene.

THE COURT: I think we better do that. We will recess until we take care of these other matters. If you will go to the back of the room, I will take the criminal matter.

(Recess)

THE COURT: You may continue your cross-examination, Mr. Dunn.

MR. DUNN: Thank you, your Honor.

Q Mr. Petersen, going back to your testimony with respect to the hiring of persons on the methadone maintenance treatment program, to your knowledge has the Kennecott Copper Company ever hired a person knowing that he was on the methadone maintenance treatment program?

A I don't know how to answer that question because I don't know.

THE COURT: I think really you ought to try to draw as much significance as you can from my questions. I'm sorry I butted in on your cross, but I think he has basically told me that he does not know specific details on the hiring, and I think that is basically it. He knows about seven instances of voluntary self-referral, if you want to put it that way, by heroin addicts, heroin people, and really does not know the specifics about what they did.

MR. DUNN: I wanted to inquire as to if some of these seven heroin addicts were treated.

Q What occurred in each case when an employee came forward and I assume he said to somebody in management, "I'm addicted to heroin," or words to that effect? What actually occurred when these people sought help?

A Well, again, because it is a confidential program and I'm not privy to the details -- I'm not supposed to be -- I could only tell you this: That a heroin addict comes in to see Otto Jones in the Insight program. Otto Jones sits down with him, goes over his history with him and then makes a determination as to what would be the best referral source for this man.

Now, I can't tell you to whom these seven heroin addicts were referred, except that I know that one at least was on methadone maintenance, because we even arranged to change his shift for him so that he could work the afternoon shift so that he could take methadone on the day shift.

Now, some of the referrals are to the psychiatric community. Some of the referrals are to Odyssey House. Some of the referrals may be to the University of Utah Drug & Alcohol Clinic. I don't get into those kinds of details. I don't run the program. I keep very close track of it, however, statistically.

Q Do you have a company rule with respect to the use of narcotics by employees?

A No.

Q You would permit employees to use narcotics?

A We can't -- we don't know how many employees use narcotics. We don't know how many use them on the job, and I doubt that any employer in America knows.

Q Is it a violation of any of your rules, Mr. Petersen, for an employee to use heroin on the job?

A Not specifically, but we do have a rule that says that the drinking of alcohol or the use of drugs on the job is prohibited.

Q Under what penalty?

A Then you decide the penalty based on a hearing.

Q What is the maximum penalty for using drugs?

A The maximum penalty for any violation of rule is discharge. That may be ameliorated because of certain circumstances. It is not a hard and fast thing.

Q Does your counseling service follow up or keep [illegible]s on each individual that seeks assistance and is referred to another agency?

A Yes, they do. As a matter of fact, it is one of the basic prerequisites of the program, to follow them. If something that doesn't work, we try something else.

Q Do these seven heroin addicts -- is their continued employment contingent upon satisfying the counseling service that they are participating in some form of therapy or treatment?

A No, it is not. Their continued employment is completely dependent upon their job performance on the job.

Q You testified that there was difficulty with respect to certain definitions such as when an alcoholic is cured. You testified that an applicant for employment who presents himself with needle marks on his arm, who is asked by the examining physician with respect to his narcotic history and states that he had been addicted and is no longer addicted; that the examining physician makes inquiries to satisfy himself that the individual is rehabilitated. What do you mean by rehabilitated, Mr. Petersen?

A That he is in a course of rehabilitation and doing satisfactorily or is no longer dependent on drugs in order to operate. The same approach we use with ex-felons.

THE COURT: What is your policy with ex-felons?

THE WITNESS: For years we have cooperated with the Utah State Penitentiary on what we call a work release program. In the last six months of their incarceration employees recommended by the State Prison we will employ. Not all of them, but some of them. Six months later, when they get out of prison, they got a job. The prison itself transports them back and forth. It is only a distance of about 25 miles. We also work with parole people on the same basis. Those come through my office. I check them out. If the prognosis is pretty good, we will employ them. Our feeling is that if nobody in America ever employs anybody whoever made a mistake, pretty soon the scrap heap will be bigger than the non-scrap heap.

THE COURT: You say you have a program, this program called Human Affairs.

THE WITNESS: I don't, but Otto Jones has.

THE COURT: Does Otto Jones consult with any railroad or subway company or transit authority or anything like that?

THE WITNESS: I can't answer that question. I don't know. I know a little bit about Human Affairs. We have had between 600 and 700 different organizations either come to see us or to ask us for our material, because they are interested in this Insight troubled people concept.

I tried to persuade Kennecott to set up a separate center because we feel that this program is the best in the country and performs an amazing amount of good and pays a good return, but they are in the business of making copper and not in the business of rehabilitation, so that Otto Jones organized this company.

Now, at this point the Geneva Works of U. S. Steel in Utah has adopted this program completely and the service that is being provided by Human Affairs. The South Chicago Works of U. S. Steel in Chicago has also purchased this program from Human Affairs.

THE COURT: Mr. McLaren, who has been personnel director of the Transit Authority testified on Friday and he said that in his view the Transit Authority or maybe people like the Transit Authority were the second most dangerous employers in the country on the basis of frequency and severity of accidents, second only to coal mining.

Now, I have a couple of questions that come to mind. Do you think that your mining operations is any more dangerous than coal mining?

THE WITNESS: No. I think that it is very easy to find out which industries are most dangerous by going to the statistics of the National Safety Council, and I would be guessing, but I wouldn't be far off to guess that the lost time and frequency rate in coal mining is 30 -- 30 lost time accidents per million hours' exposure. Our company's average in open pit mining, the kind we are engaged in, runs about 9 to 10. The automobile industry, for example, is like 1.44.

THE COURT: So coal mining is pretty high?

THE WITNESS: Coal mining is pretty high. I have no idea what the Transit Authority is. I just have no idea at all.

THE COURT: Go ahead.

Q Do you have any idea, Mr. Petersen, what the work record has been of each of the seven heroin addicts that are under treatment?

A No, sir, I don't. I do not because, again, this entire program is voluntary and confidential. I don't even know the names of them. I don't know which plants they come from and I don't know how many more heroin addicts there are out in those plants.

Q I'm talking about the seven you are aware of, Mr. Petersen. Can you give me some idea what their stability is as employees?

THE COURT: He said he doesn't know the specifics.

Q In your statement, Mr. Petersen, you said:

"We consider the program which covers alcoholics and persons with psychiatric problems as well as drug addicts to be highly successful both in terms of employee stability and productivity."

Are you including the seven heroin addicts?

A I certainly am. There is no evidence to indicate that they are less productive than anybody else.

Q Is there any evidence to indicate that they are as productive?

A No, I don't know who they are. I'm not supposed to know who they are. The program wouldn't work without confidentiality .

Q Sir?

A The problem can't work without confidentiality. Nobody would come forth to be helped.

MR. DUNN: I have no further questions, your Honor.

THE COURT: Thank you very much.

MR. MORRILL: I have just one or two.

REDIRECT EXAMINATION

BY MR. MORRILL:

Q Mr. Petersen, are you aware of whether or not there is a drug abuse problem in the Salt Lake City area?

A Yes, I'm aware of it from two sources. One are the newspaper accounts -- three sources. Number two, from our own program and three, the fact that there are at least three heroin treatment modalities in Salt Lake City.

Q Are there a number of Vietnam veterans in the Salt Lake City area?

A Yes, there are.

MR. MORRILL: I have no further questions.

* * *

STATEMENT OF HENRY D. BIGGART

Vice-President, Community and Customer Services,
New York City Off-Track Betting Corporation

I have served as Vice President for Community and Customer Services of the New York City Off-Track Betting Corporation (O.T.B.) since the start of the Corporation in 1971. In that period of time, O.T.B. has made a special effort to employ persons whom some other industries have been reluctant to employ. I am appearing today to describe the experience of O.T.B. with the employment of persons with a history of drug addiction, including persons maintained on methadone.

Two O.T.B. branches, one at 1133 Broadway and another at 575 Lexington Avenue were opened and staffed entirely by ex-addicts. The Corporation relied on the Vera Institute of Justice to pre-screen persons in methadone programs for work readiness. The basic criterion used by Vera was that the person have been enrolled in a treatment program for at least six months and making progress. Of this group, Vera selected persons previously deemed to be hard core unemployable because of the length of time of their addiction or other factors.

The persons referred by Vera were employed as cashiers in the two O.T.B. branch offices. For a period of time, a counselling program was available, but this program was withdrawn during 1974.

At no time did the employees in the two "Vera" branches receive more supervision than comparable employees in other O.T.B. offices.

The position of cashier in an O.T.B. office is a responsible and largely unsupervised job. Cashiers are responsible for their own cash with no on-going supervision. Thus, when a cashier goes to lunch or for a coffee break, he or she locks the cash box, and there would at that point be no way to tell if the employee was taking cash out of the office. A cashier can be fined, suspended or fired for shortages discovered at the end of the day. The amount of cash handled by each employee is large...often as much as $4000-$10,000 a day.

The position of cashier in an O.T.B. office also involves a good deal of stress and strain on the employee. Besides being responsible for large amounts of cash, the employee is often also subject to severe abuse from customers. Twice a day the branches become very crowded, and long lines form.

Our experience with the employment of persons with a prior history of drug addiction has been highly favorable. For example, of the ex-addicts originally hired to staff the 575 Lexington Avenue branch, 10 have been promoted, and now work in other O.T.B. branches; 2 have become branch managers, 4 have been transferred to other branches, and 9 have resigned or been terminated. None has been terminated because of a resumption of drug use. The attrition rate is approximately equal to the overall attrition rate at O.T.B.

Of the 14 ex-addicts hired in August 1972 to staff the 1133 Broadway branch, one has been promoted to cashier in a regular O.T.B. office, one has been transferred to the O.T.B. central office as a research assistant, and two have been terminated, producing a monthly negative termination rate of 1.9% compared to 2.3% for the corporation as a whole. One termination was due to repeated lateness and absence; the other was due to the use of soft drugs and to excessive absences. The employee who is now a research assistant at the O.T.B. central office was transferred because his new position was more suitable to his ability and preference.

The principal indicia of performance of O.T.B. branches are overall attendance records and cash shortages. In both respects, the two branches staffed by ex-addicts have been indistinguishable from other O.T.B. branches.

In brief, the experience of O.T.B. with the employment of rehabilitated former drug addicts has been that they have performed as well as the population at large of O.T.B. employees. They have performed capably and dependably in a responsible and high stress work situation. We have concluded from our experience that neither former drug history alone nor participation in a recognized methadone maintenance treatment program is a reason to disqualify a person from work with large amounts of cash in an essentially unsupervised high stress situation.

CARL A. BEAZER et al

- v s - 72 Civ. 5307

NEW YORK CITY TRANSIT AUTHORITY.

October 29, 1974

9:10 a.m.

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* * *

HENRY DAVID BIGGART, called as a witness by the plaintiffs, having first been duly sworn, testified as follows:

MR. MORRILL: Your Honor, I would like to have marked as Plaintiff's Exhibit next in sequence, the statement of Mr. Biggart.

xx (Plaintiff's Exhibit 44 marked for identification.)

DIRECT EXAMINATION

BY MR. MORRILL:

Q Mr. Biggart, could you tell us when you handed to me the last revised edition of your statement for the first time?

A Today, as I walked into this room for the first time.

Q Approximately how long ago was that?

A Approximately a half an hour ago.

Q Thank you.

Mr. Biggart, have you examined this statement?

A Yes, I have.

Q Do you adopt this statement as your direct testimony in this case?

A I do.

MR. MORRILL: I have no further questions of Mr.

Biggart.

THE COURT: All right, we will receive Exhibit 44.

MR. MORRILL: I would like to move its admission into evidence.

xx (Plaintiff's Exhibit 44 received in evidence.)

THE COURT: All right, let's take a minute and read it.

(Pause)

THE COURT: Can we go ahead with cross?

MR. DUNN: Your Honor, I move to strike from the statement the witness' statement as to what the Vera Institute did, and why the Vera Institute did certain things.

THE COURT: All right, let me look at that, please. Where is that?

MR. DUNN: It starts with the basic criterion of Vera, which I assume is the criterion applied by the Vera Institute.

THE COURT: I assume that was the basic criterion of the Off-Track Betting Corporation.

THE WITNESS: That is correct.

MR. DUNN: But the statement first alleges that the Vera Institute was relied upon with respect to the pre-screening, and then refers to a basic criterion.

THE COURT: He has just tole me that was -- when he speaks of criterion, it is by his company, the Off-Track Betting Corporation, so that clears that up.

MR. DUNN: "Vera concentrated its attention on persons previously deemed to be hard-core unemployables."

THE COURT: Are you moving to strike that?

MR. DUNN: Move to strike that and the remainder of the sentence.

MR. MORRILL: Your Honor, I would think to the extent this reflects the understanding and the reliance --

THE COURT: His understanding -- I will strike that sentence. Strike it out. It is just hearsay.

MR. MORRILL: Your Honor, this was the criterion which Off-Track Betting relied upon, and it is certainly relevant, perhaps not for the truth of the matter --

THE COURT: All I am interested in is the facts which this man knows. He knows who he hired and he knows how they did, but to -- as far as saying as a matter of fact that Vera concentrated on this and that, I think I will strike that. I will strike the last sentence.

MR. MORRILL: Can't it be admitted solely for the purpose of showing the willingness of the employer?

THE COURT: But that's irrelevant. They are not being sued. Off-Track Betting is not being sued. That's irrelevant.

Okay. Go ahead with your cross.

CROSS EXAMINATION

BY MR. DUNN:

Q Are you presently employed by the Off-Track Betting Corporation?

A Yes, I am.

Q I call your attention to a sentence that we referred to earlier in your statement: "The basic criterion applied was that the persons had been employed in a program for at least six months and making progress."

MR. MORRILL: I believe that's a typographical error and should be "enrolled."

MR. DUNN: I am asking the witness, counsel.

MR. MORRILL: Your Honor, my secretary typed it for him and I didn't correct it.

THE COURT: Is there a typographical error?

THE WITNESS: Yes, there is.

THE COURT: What sentence is that?

MR. MORRILL: It is in the second paragraph, your Honor, third line from the bottom.

THE COURT: What's the error? Let's have it from the witness, please.

THE WITNESS: The terminology should be: "enrolled" as opposed to "employed." These are ex-addicts.

THE COURT: Okay, we will change that.

THE COURT: All right, Mr. Dunn.

MR. DUNN: Should we deem that word to be "enrolled" rather than "employed?"

THE COURT: Yes.

BY MR. DUNN:

Q How many versions of this statement have been prepared, Mr. Biggart?

A How many versions of this statement?

Q Or drafts.

A I am aware of only one rough draft of this statement from which this was finalized. This is the final.

Q How does this differ from the rough draft?

A Typographical errors, I am surprised we overlooked "enrolled" instead of "employed," but things like that.

Q These two branches that you refer to, the Broadway branch and the Lexington Avenue branch, they were staffed entirely by ex-addicts?

A That's correct.

Q What percentage of these ex-addicts were on the methadone maintenance treatment program?

A We tried to get the --

Q No, just answer my question, if you will.

A I am trying, counsel.

Q What percentage, if you know, of these employees were enrolled in the methadone maintenance treatment program?

A We tried to get a mix, 50-50.

MR. DUNN: Your Honor, may I ask the Court to direct the witness to answer the question.

THE COURT: We really want to know what you ultimately employed. Can't you tell us that?

THE WITNESS: Yes, I can.

THE COURT: What is it?

THE WITNESS: Of the initial 39 ex-addicts, 20 of them were methadone maintenance.

THE COURT: Where is the initial 39 now? I don't see that.

THE WITNESS: There were 25 ex-addicts at 575 Lexington Avenue, initially, and there were 14 of them at 1133 Broadway.

THE COURT: Now, of the 25 at Lexington, how many were methadone?

THE WITNESS: At 575 Lexington Avenue, 12 were methadone maintenance.

THE COURT: 12 were then on methadone maintenance?

THE WITNESS: Right.

THE COURT: Go ahead, Mr. Dunn.

BY MR. DUNN:

Q Of those 12 at 575 Broadway --

THE COURT: Lexington.

THE WITNESS: 575 Lexington Avenue.

Q Right, and at 1133 Broadway, there were 14 employees?

A Yes, and eight of those were methadone maintenance.

Q Will you tell me what programs these employees were participating in and the names of the methadone programs?

A I do not have that information available at this time, but I can secure the information for you.

Q What was your connection with the hiring of ex-drug addicts? Did you have a particular responsibility in that area?

A Yes. These projects reported directly to me. I was ultimately responsible for these projects.

Q Responsible in what way? Did you initiate the hiring of ex-addicts?

A I was instrumental in that process, yes.

Q And what was your role?

A I was the vice president to which this area reported.

Q You still are, aren't you?

A Yes, I am.

Q And did there come a time that you initiated this program? Was this of your own -- please strike that.

Did you initiate the hiring program with respect to ex-addicts?

A Yes, we did. The idea came out of our office.

Q And when did this occur?

A 1971, the program started, initiated in 1971.

Q And how did it come about? What was the reason for initiating such a program?

A The reason for initiating this program, we felt that Off-Track Betting was a new entity --

Q When you say "we" --

A The top level executive staff at the Off-Track Betting Corporation.

Q Please continue.

A We felt that it was a new idea and no one else had tried it, and looking around the City of New York we felt that there was a residue of people who ordinarily did not get an opportunity and we saw this as an opportunity to try to involve some of these people in a meaningful work experience.

Q Then how did you go about implementing that program?

A Our first stage of trying to implement a program to hire ex-addicts led us to people who had some experience in this area. The Vera Institute of Justice, we were aware, had some programs operating at the time, the Pioneer Messenger Service, the Wildcats which came about at a later date, I believe. But they had done a great deal of work in this area and had secured grants from LEAA to perform this social service. So we went to Vera with the idea, explaining to them what our aim was and we came up with some criteria to employ ex-addicts.

Q Who did you speak to at Vera and what did you state your aim was?

A We spoke initially with Ken Marion and Herb Stirs, who is the executive director at Vera. We stated that our aim was to employ ex-addicts within the corporation so as to, A, give them a meaningful work experience and B, demonstrate it can in fact be done.

Q What response, if any, did you receive?

A Vera was elated that someone else was willing to give these people an opportunity to experience the dignity of meaningful work.

Q What then occurred?

A We then proceeded with the hashing out of the thinking of how might this be done in a businesslike way, how might this be done in a way that would insure the confidentiality and the safety of corporate funds, and that sort of thing. All of these different things were talked about.

Q Were there criteria established for the selection?

A Yes.

Q Will you tell me, please, what the criteria was?

A The criteria was that the individual would be enrolled in a drug program and was doing successfully in that program. We sought also to select or bring in persons who were least likely to be acceptable on the open job market.

THE COURT: Meaning what kind of people?

THE WITNESS: People who had numerous arrests as a result of drug involvement.

THE COURT: And you sought to bring those people in?

THE WITNESS: Yes, we did. In our discussions with Vera it became quite clear to us that the opportunity for a dignified work experience was definitely a part of the rehabilitation process .

MR. DUNN: I move to strike that as being unresponsive to the question. I had asked what was the criteria.

THE COURT: I will let it stand.

Q Will you continue with the criteria that you established?

A That the individual would have been enrolled for six months in a drug program and doing successfully ; that he had not been imprisoned on an embezzlement charge.

THE COURT: Please start again.

THE WITNESS: That the candidate had been enrolled in a drug program for at least six months and doing well.

Q Are you refreshing your recollection by looking at some documents?

THE COURT: And the other was no conviction for embezzlement?

THE WITNESS: Yes.

Q Are you refreshing your recollection by looking at documents?

A No, I'm not.

Q I notice you have papers before you.

A This is a statement which you have, counsel.

Q And the paper on your right is what?

A Excuse me?

Q What is the paper on your right, sir?

A Page 3 of the statement. On the back of it I am making certain notes of materials I might have to get to you after I get back to the office.

Q Thank you, sir.

Were there any other criteria?

A This basically was the scope of the criteria.

Q When you say six months in a drug program doing satisfactorily in the program, are you referring to a methadone program or a drug-free program, or would it make any difference?

A To us it really did not make any difference. We concentrated on having a mix in the offices. Quite naturally we went to some methadone maintenance agencies. We went to some drug-free modalities.

Q However, one criteria was that the person must have been enrolled in a program for six months?

A That is correct.

Q Did you do any other sort of monitoring or study of the persons that were hired in this program?

A That were hired by OTB?

Q Yes.

A Yes. As indicated in my statement, we kept track of these individuals, what happened to them after they were employed by OTB: Was this individual promoted? Was he terminated? Was he fired for reverting back to the usage of drugs? And that sort of thing. So we did keep track of them for one year.

After six months in what we described as the controlled environment -- by the controlled environment we mean the branch office in which all of his peers are ex-addicts. After six months in that environment this individual was now ready to be phased into our overall operation. We had to monitor the progress these individuals were making as far as work performance and that sort of thing to determine their readiness to be phased into the overall system.

THE COURT: Did you intentionally start these people out in offices where everybody else would be ex-addicts?

THE WITNESS: That is correct.

THE COURT: You thought that would be safer than starting them out by mixing them in with the ordinary work force?

THE WITNESS: As an experimental project, yes. We soon found out, however, that there was no need for what we felt were the necessary supportive services that this individual might need in order to perform, such as a counselor on the site. These things became unnecessary and we discontinued the process of having a counselor on the site.

We also hire ex-addicts right in our overall system today as a result of the successful experience we had with the pilot projects.

Q What criteria do you apply in considering an ex-addict for employment today?

A Again, we look at what type of program he is coming from, we look to see whether there is any criminal record and the extent of that, and it is basically the same criteria utilized in the projects which we did with the Vera Institute for Social Justice.

Q Has there been a change between yours and the Vera Institute and any of the programs which your employees have been or are enrolled in, that is, an exchange system where you compare notes or are you engaged in some sort of colloquy with respect to the success or lack of success of the program?

A Yes, we do. In conjunction with the Vera Institute of Justice we have issued a semi-annual progress report and then an annual progress report which was designed to take a good, hard look at what these people were doing and comparing them to other situations that Vera was knowledgeable about.

Q So this was issued by whom?

A The Vera Institute of Justice.

Q And have you engaged in any sort of colloquy between the programs also and OTB?

A We depended very heavily on the Vera Institute of Justice to, you know, bridge that gap for us. They were trained in this area. They had the necessary people with the expertise to communicate at that level, so we depended greatly on Vera to bridge that gap for us.

Q Are you referring to the initial hiring phase or are you relying on Vera after the employee enters your employ?

A After the employee entered our employ Vera was quite helpful in finding out and communicating with agencies from which this individual came.

Q And to what extent did Vera assist you after the person became an employee?

A Let me give you an example. If an individual on methadone maintenance, an ex-addict on methadone maintenance--if this individual had some problem at some point getting his dosage of methadone, this might affect his work performance. As I'm sure you know, there are problems at times with people having access to proper treatment facilities and that sort of thing. Vera was very helpful in finding out what the problem was down the line, as they had people who were trained in this area.

Q Did Vera provide you with any assurance that the employee was continuing in a program?

A Yes.

Q To what extent and how did they provide this assurance?

A We had a standing meeting with the Vera Institute of Justice at which we discussed progress of individuals and problems of individuals. In any group you have some bad apples. It was at that time that they would advise us of any problems individuals might have with treatment agencies and that sort of information.

Q Would they identify the problem with the individual?

A Yes.

Q And they would say, "John Smith is having this problem" to you?

A Yes.

Q What were some of these problems?

A An individual might have a problem with his family. The individual might have a problem making his budget go around, and that sort of thing. We, our staff -- it related to a part-time situation and in some instances it was not enough for this individual to subsist, so he had budgeting problems. We found that full-time employees, a full-time situation where the individual is totally involved is much better.

THE COURT: How many hours a week did the employees of the two branches work? How many hours a week did an employee at each of the branches work?

THE WITNESS: They averaged not less than 20 hours.

Q Essentially they were working about half-time; is that correct?

A Yes.

THE COURT: Are we still talking about the original 25 at Lexington Avenue and 14 at Broadway?

A Right. I am still on the original 25 at 575 Lexington Avenue.

Q That was my understanding, sir.

A Right.

Q I asked the number of hours an employee works.

THE COURT: You said he only averaged 20 hours?

THE WITNESS: Not less than 20 hours a week.

THE COURT: What did they in fact average?

THE WITNESS: About 20, 25 hours.

THE COURT: Why was that?

THE WITNESS: There were days people were ill. There were days when the work was heavy and that sort of thing. There were days when we had computer problems. Initially, in those days, our computer system was not as stable as it is today. We had numerous breakdowns and there was a great deal of overtime put in by these people, so they usually ran 20 or 25 hours overtime.

THE COURT: You say overtime of 20 or 25 hours is less than the normal work week?

THE WITNESS: Yes, but they are hired as part-time cashiers.

THE COURT: What would be the normal workday for a normal, part-time cashier?

THE WITNESS: 20 hours.

THE COURT: Were they hired as part-time cashiers because of the drug situation?

THE WITNESS: No. Our staffing pattern called for part-time employees. We needed people there when there was a crush of business and in order to staff that way we had to hire part-timers.

THE COURT: You would have hired this grade of people who had no connection with drugs?

THE WITNESS: Yes.

Q Was it your need to have part-time cashiers?

A Yes.

Q You weren't doing it because of people feeling their disability?

A No.

THE COURT: Before we leave this, I want to know this: how many methadone people or former heroin addicts have you hired since the original 25 at Lexington Avenue and 14 at Broadway; how many in addition to those?

THE WITNESS: We have processed through 23 additional persons at 575 Lexington Avenue.

THE COURT: What is that?

THE WITNESS: 23 additional people at 575 Lexington Avenue.

THE COURT: Any others?

THE WITNESS: And three additional people at 1133 Broadway.

THE COURT: Any others?

THE WITNESS: There are others throughout the corporation. Those figures I do not have at my disposal. They did not come through the special projects. They were hired by the corporation at large.

THE COURT: Can you give me an estimate?

THE WITNESS: I wouldn't want to guess. I would rather get the information back to you.

Q How many ex-addicts were hired to fill full-time positions as opposed to part-time positions?

A We hired 14 full-timers at 1133 Broadway.

Q I take it all of the ex-addicts you are referring to are ex-heroin addicts?

A No.

Q No?

A No, I'm not. Eight of these people were methadone maintenance people.

Q But they had all been heroin addicts, had they not?

A You mean they all had been addicted as a result of heroin?

Q Addicted from heroin.

A I couldn't answer directly. I'd have to check and find out.

THE COURT: Let me see, going back to the original 39 at Lexington and Broadway, aside from the eight methadone people, you don't know how many others had been addicted to heroin?

THE WITNESS: That is correct.

Q Going beyond the original 39, Mr. Biggart, how many of the ex-addicts would be addicted to heroin?

A Beyond the original 39 hired by the corporation?

Q Yes.

A For these special projects?

Q You said that the first 39 --

THE COURT: You are talking about the second group of 23 at Lexington and three at Broadway, 26?

THE WITNESS: Yes.

THE COURT: How many of them were on methadone?

THE WITNESS: Twelve.

Q How many had been heroin addicts?

A Again I'd have to check the addiction of the others.

Q Would you have any records that would establish that?

A Yes, we did.

Q What type of records would you have that would show them?

A Well, we can get it from the Vera Institute of Justice.

Q Records in your own possession at this time and the possession of OTB.

A This information would have to be gotten from the Vera Institute of Justice.

Q You cannot determine from your own records at OTB which of these persons had been heroin addicts?

A I'm sure that that information can be retrieved from the personnel files. Again, I would have to check with our legal department to determine whether, you know, that information taken out of the personnel file would be available.

Q I'm asking only for the information as contained in the files.

A I would think that the source of that information would be the Vera Institute of Justice.

Q I am asking, Mr. Biggart, whether in the files of OTB it can be ascertained as to whether each of these persons had a history of heroin addiction. Does that information appear in your files?

A The OTB records -- I'm not certain it does.

Q You mentioned in your statement that one termination was due to the use of soft drugs. What drugs were involved?

A Marijuana.

Q Is the use of marijuana a violation of the rule of the Off Track Betting Corporation?

A It was a violation of his treatment agency.

Q Which treatment agency?

A This individual was a methadone maintenance patient.

Q Which program, sir; do you know?

A I would have to get that information for you. It was discovered that this individual had been using marijuana, smoking marijuana. The information was brought to our attention by Vera, who was in contact with this agency and for that reason the individual had to be terminated.

Q How did Vera become aware of the fact that the individual was smoking marijuana?

A As I said, there was initially a counsellor on the jobsite. This counsellor --

Q Paid by whom?

A He was paid by OTB. This counsellor had frequent conversations with the candidates, filed his reports and --

Q When you say "candidates," were they employees or --

A Employees.

Q Please continue.

A I would think that that might have been where it was initially discovered.

Q Was he smoking marijuana on the job?

A Yes.

Q You say he was terminated because it was a violation of the methadone program regulation?

A Yes.

Q Was there an understanding that he had to maintain a level of participation in the program to which he was committed?

A No. No, it was not.

Q But you said that Vera brought this information with respect to the smoking of marijuana to your attention, did you not?

A Yes.

Q And you said that the information had originally been gleaned by the counsellor employed by OTP?

A To the best of my recollection it was.

Q How did Vera become aware of it, and the counsellor?

A Vera sat in weekly sessions --

MR. MORILL: I am going to object to the question about Vera. Mr. Dunn feels strongly that the witness should not testify as to Vera.

THE COURT: Sustained.

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THE COURT: When were the additional 26 hired?

THE WITNESS: They were hired at different periods to replenish the staff at 575 Lexington Avenue and 1132 Broadway. I would have to get the initial startup dates of each one of those people.

THE COURT: Did I understand that you did not communicate or receive reports from the treatment agencies directly; you relied on Vera to provide whatever information was provided; is that correct?

THE WITNESS: That's right, sir.

THE COURT: And you don't know, sitting here, the names of the treatment agencies for the methadone people, right?

THE WITNESS: No, I do not.

THE COURT: Now, I am not clear. Was there a specific system for Vera to report to you your analysis results or any systematic provision for reporting to you information about these people and how they were doing with their treatment facilities?

Did you meet with them regularly? I am not clear.

THE WITNESS: Okay, let me see if I can run through the process.

Vera did the prescreening of the candidates for employment with OTB. Vera made recommendations to OTB that Candidate A was satisfactorily in performance with the treatment agency and was ready to take the initial tests for employment with OTB.

The individual then was tested by OTB and if he passed the test, he was then placed in 575 Lexington Avenue, that branch office.

Thereafter, there were weekly meetings with the counselor at the branch office, the Vera Institute of Justice, and my staff at OTB to review progress of these individuals on a weekly basis.

THE COURT: Now, what kind of information is given to you by Vera at these weekly meetings?

THE WITNESS: The counselor at the office might indicate that John Jones has a consistent lateness pattern, or a consistent Monday-absent problem, and this is something we should work with him on and talk to him and find out what his problem is.

THE COURT: Then what would happen?

THE WITNESS: It was then the counselor's responsibility to find out what the source of that problem was and work with--

THE COURT: The counselor at Vera?

THE WITNESS: The counselor at the branch office at OTB.

(Continuing) -- to work with that individual and determine what his problem was and devise ways to resolve the problem.

THE COURT: What would Vera do?

THE WITNESS: Vera would offer us advice and coursel in this area as they had, you know, a great deal of experience in the employment of ex-addicts.

THE COURT: What I am wondering about, each of these men was a patient at some methadone facility, right?

THE WITNESS: That is correct.

THE COURT: Now, would Vera report to you? Would Vera go to the facility and ask about the man and report back to you any information that might be relevant from the treatment facility?

THE WITNESS: To the best of our knowledge, that communication did exist between Vear and the treatment agencies.

THE COURT: Well, I am wondering about - did Vera report to you any information coming from the treatment facilities, that maybe he was not showing up for his methadone?

THE WITNESS: Yes.

THE COURT: Or he had a urinalysis which indicated the use of drugs, or any one of a number of other things that might be useful information? Would they report to you?

THE WITNESS: Yes.

THE COURT: You seem hesitant.

THE WITNESS: There was certain information that Vera could not retrieve from treatment agencies.

THE COURT Yes?

THE WITNESS: There was confidential information as far as these ex-addicts were concerned which the treatment agencies were not at liberty to hand out. But whatever information Vear was able to get from the treatment agencies was a part of their ultimate decision in the recommendation of the candidate for employment with OTB.

THE COURT: Now, can you give me any specific information about the methadone people?

You have named a total of 20. The first group, 8 out of 39, the second group, 12 out of 26, a total of 20.

Now, how many of those 20 are still with OTB?

THE WITNESS: I could have to cull that information from the records.

THE COURT: How many of them had any absence problems, lateness problems; was there any observation of any problems at all?

THE WITNESS: What we observed as far as the lateness and absence patterns of these individuals that were employed at 575 Lexington Avenue and 1132 Broadway was that their absence pattern was no greater than the average or norm at OTB.

THE COURT: Were the methadone people employed as cashiers?

THE WITNESS: Yes.

THE COURT: Anything else, Mr. Dunn?

MR. DUNN: No, I have concluded cross-examination.

THE COURT: Any redirect?

MR. MORRILL: One question.

THE COURT: All right.

REDIRECT EXAMINATION

BY MR. MORRILL:

Q Mr. Biggart, did you ever ask Vera, or any other agency, or any of the treatment agencies, excuse me, for any information that you felt was necessary for the efficient and safe operation of your business and have that question refused?

A No.

MR. MORRILL: Thank you.

RECROSS EXAMINATION

BY MR. DUNN:

Q What information did you seek from Vera that was supplied to you?

MR. MORRILL: Your Honor, I am going to object to that as beyond the scope of redirect.

THE COURT: I believe we covered that. We are just starting up again.

MR. DUNN: Counsel just asked whether any information has been saught from Vera.

MR. MORRILL: Your Honor, I asked whether he had been ever refused any information he deemed necessary.

MR. DUNN: I will withdraw it, your Honor.

THE COURT: You may step down.

(Witness excused.)

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CARL A. BEAZER, et. al,

Plaintiffs

-against- 72 Civ. 5307

NEW YORK CITY TRANSIT AUTHORITY,

Defendants.

October 30, 1974
10:30 a.m.

- - -

* * *

LOUIS A. LANZETTA, called as a witness on behalf of the defendants, being first duly sworn, testified as follows:

DIRECT EXAMINATION

BY MR. SUMMERS:

Q Doctor, what is your present occupation?

A I am now a medical director of the New York City Transit Authority.

Q How long have you held that position?

A Four years.

Q And before that time, did you hold any position with the Transit Authority?

A Yes, previous to it I was assistant medical director.

Q For how long?

A For about two years.

Q Before that?

A I was a medical supervisor previous to that for about two years, and about twenty years as a physician and surgeon part-time for the New York City Transit Authority, all told 28 years.

Q You have been associated with the Transit Authority for 28 years, is that right?

A That's correct.

Q Now, is your present job a full time job?

A It is.

Q And during these 28 years, were you also engaged in private practice?

A I was, up to the time when I took on a full-time job as a medical director.

Q And how many years is that you were engaged in private practice?

A I was in private practice about 36 years.

THE COURT: When did you go on full-time at the Transit Authority?

THE WITNES: 1970.

THE COURT: So, when you became -- when you took your present position?

THE WITNESS: That's when I closed my office.

Q Where did you conduct your private practice?

A I practiced in East Harlem.

Q What street?

A 116th Street.

Q Now, when did you graduate from medical school, Doctor?

A I graduated from Long Island College of Medicine, which is now Downstate, in 1933.

Q Having graduated, what did you do; did you go to an intern--

A I interned at Metropolitan Hospital.

Q And while you were at Metropolitan, did you engage in any drug services?

A Yes. In 1933, they did have a detoxification ward at Metropolitan Hospital in those days, but, oh, I think it was about a year later they had to close it down in view of the fact we had no success in view of the fact the drug was brought in and these people, we were unable to detoxify them.

Q What I'm getting at, did you participate in the administration of that detoxification?

A Definitely. I was assigned to that ward for a period of time.

Q What other hospitals have you been associated with?

A I was an associate physician at Mother Cabrini Memorial Hospital.

Q For how long?

A About 32 years.

Q Now, do you belong to any professional association?

A Yes.

Q What are they?

A I belong to the New York County Medical Society, the American Medical Association, and the Association for Occupational Medicine, which previously was the Industrial Medical Association.

Q Do you consider yourself a specialist in any area?

A I feel my subspecialty would be in industrial medicine, in view of the fact that I spent so much time, especially in Transit.

Q This is based upon your 26 --

A My practical experience working with the Transit Authority for 28 years. And also attending the seminars of the Industrial Medical Association and numerous other seminars.

Q Are these annual seminars?

A Correct.

Q Do you attend each of them?

A Yes, annually.

Q Now, as the medical director of the Authority, did there come a time when you became aware of the possibility of drug use among Authority employees?

A Well, about 1970, among our employees, I felt we were having a problem because of absenteeism, behavior problems, and at that time, I spoke with Dr. Baden.

Q Who?

A Baden, B-a-d-e-n, who was the medical director office, and asked him if we could possible use his laboratory for urinalyses for drugs.

Q He was head of the what medical director's office? The T.A.?

A No, I said Dr. Baden, who was the director of the medical -- not the director's office -- the medical examiner's office, New York City.

Q That's the City Medical Examiner's office?

A Medical Examiner's office and I asked permission to send urine for analysis. And following the results, where we had a number of positive findings of morphine, I spoke to Mr. McLaren and the executive officers that we should start a program, actual program, in the detection of drug addicts in the Transit Authority.

Q You mean, employees?

A Employees and also expanding this program in the pre-employment area.

Q You mean applicants for employment?

A That's correct.

Q All right.

Did you implement that advice you gave to him?

A Yes. In the case -- implementing this program, the urinalysis for drug addiction was done first on all suspicious cases. Number two, on every individual below the age of 35 that came in for a periodic examination as a bus operator or a motorman; all applicants below the age of 35.

Q Now, did you do anything at that time or subsequently to acquaint yourself with what was going on in this area or drug abuse?

A I did.

Q What did you do, will you tell the Court?

A On a number of occasions I was at Beth Israel Hospital where I had a number of sessions with Dr. Galance,. G-a-l-a-n-c-e..

Q I'm sorry, I think it's spelled G-o-l-l-a-n-c-e. We had that mistake made before.

A And I also had a number of sessions with Dr. Trigg.

Q Now, who is Dr. Trigg?

A He was the medical director of the methadone center at Beth Israel.

THE COURT: We have had reference to Dr. Gollance, but can you refresh my memory, who is he or who was he?

THE WITNESS: He was the assistant medical director of the methadone center. He worked with Dr. Trigg.

THE COURT: Dr. Trigg was the director?

THE WITNESS: That's correct.

THE COURT: Of the Beth Israel Methadone?

THE WITNESS: Yes.

THE COURT: Would that make Dr. Trigg the director of the Methadone Program of Beth Israel?

THE WITNESS: Of Beth Israel Hospital. Beth Israel, yes.

THE COURT: And Dr. Gollance was his assistant?

THE WITNESS: That's correct, sir.

MR. BALBER: Your Honor, for the purpose of clarifying the record, Dr. Gollance is the director of the entire Beth Israel Medical Center.

THE WITNESS: I was under the impression --

MR. BALBER: I was trying to clarify it.

THE WITNESS: Maybe in 1970 when I saw him, Dr. Trigg

I thouth was the medical director of the Methadone Center of Beth Israel Hospital.

MR. BALBER: It is a stipulated fact, your Honor, on page 19.

THE COURT: I'd like to -- we have got a stipulation 21 which names Dr. Harvey Gollance as director of the Beth Israel Medical Center.

THE WITNESS: Medical Center, not the Methadone Center. I am talking about the Methadone Center.

THE COURT: Let's take it one step at a time.

So we have got it stipulated that Harvey Gollance was director of the Beth Israel Medical Center, is that right?

THE WITNESS: Yes, but he also --

THE COURT: Okay, let's go.

THE WITNESS: Right.

THE COURT: Then the methadone situation we have got Dr. Harold Trigg as chief of the Methadone Maintenance and Drug Addiction Services at the Beth Israel Medical Center?

THE WITNESS: Correct.

THE COURT: Now, did Dr. Gollance have anything to do specifically with the methadone services at Beth Israel?

THE WITNESS: Yes. I felt he did, because when I first called to have an appointment with Dr. Trigg, I was referred to Dr. Gollance and Dr. Gollance said he would certainly be able to help me in discussing the methadone program. In fact, he was the one that made the appointment for me to see Dr. Trigg, and it was my impression that he did work with Dr. Trigg on the methadone center.

THE COURT: Okay, go ahead.

(Continued on next page.)

BY MR. SOMMERS:

Q Did you also visit the facilities --

A I also spoke to, had numerous conversations with Dr. Baer who ran a drug haven.

Q Where?

A In East Harlem.

Q Is that a methadone maintenance program?

A No, not a methadone, but in the treatment of drug addicts.

THE COURT: How do you spell his name?

THE WITNESS: B-a-e-r.

THE COURT: He ran what?

THE WITNESS: This drug haven, which is located at 116th Street between Second and Third Avenue. I don't know the exact address there.

THE COURT: What do they do there?

THE WITNESS: Of course, he practices medicine but he is interested in research in drugs.

THE COURT: What does the drug haven do?

THE WITNESS: It is more on the -- I would say the same thing as the AA in alcoholics. In other words, abstaining.

THE COURT: Go ahead, Mr. Summers.

Q Besides conferring and talking with the people you mentioned, did you visit any other facilities that were engaged in drug treatment?

A Yes.

Q What were they?

A I spent the whole afternoon at Phoenix House.

Q Is that in New York City?

A No, that was in Brooklyn. I had quite a chat with the director.

Q What kind of therapy, drug therapy are they engaged in?

A There again it was abstinence.

Q Did you also visit --

A I also visited -- I don't know exactly whether it was Odyssey House. It was on the west side at 127th Street. It was run by a reverend. On both occasions Mr. McLaren was along with me.

Q You and Mr. McLaren?

A Yes. On all these occasions, because he and I always conferred.

Q During your private practice in Harlem, East Harlem, did you have any patients who were drug addicts or using drugs?

A Numerous. Numerous. There was a high concentration in that area around 107th Street and Pleasant

Avenue. In fact, I think among the first patients that Dr. Dole had on methadone was one of my patients when he was doing his work, his research work at Rockefeller Institute. I think there were two of my patients and very unfortunately both of them would go on and off the program and never did succeed in getting off heroin.

Q Did you ever confer with Dr. Dole?

A No, I never did. I never did confer.

Q Have you kept abreast of the professional literature dealing with drug problems in society?

A The question of the drug problem or methadone, let's say, definitely is not enough --

Q Have you kept abreast of the literature?

A I have definitely kept abreast. I definitely have kept abreast. In fact, the last seminar I went to was in -- I want to give you the exact date. The last seminar I went to was in February 1974, this year. It was the Bureau of Narcotics & Dangerous Drugs.

Q Is that the Department of Justice?

A Yes.

Q In Washington?

A No, no. It was held at the Commodore Hotel. I think it was at the Commodore.

Now, at that seminar they had numerous workshops.

Do you want me to go on?

Q Just generally tell us, did these workshops deal with the use of drugs by employees in industry?

A Yes, I was with the medical directors of different outfits and methadone and drugs were discussed.

Q You exchanged views?

A That is correct.

Q Did you arrive or did you think there was any concensus among these medical directors whom you conferred with respect to the employment of people on methadone?

A Yes.

Q What was it?

A Well, it seemed that the medical directors of organizations like Metropolitan Life, I believe or Equitable Life, had pilot programs where they did hire methadone people, but there was also a union official for a construction company and, of course, I was there and we both felt that in hazardous jobs or in driving vehicles that we should not use people on methadone.

Q Why not?

A The union official stated emphatically that he would have no one on any of his construction sites who was on methadone for fear of injury to himself or to his other employees.

Now, at the end of this workshop session there was a general discussion, you know, a general discussion. Someone got up to crystalize what went on and it was brought out that not enough was known about methadone, but they certainly felt that a man on methadone should not operate a vehicle or be in any dangerous area.

Q When you say "they," are you referring to the medical directors who participated?

A Well, the panel. The panel that was there.

Q They were mostly doctors?

A Well, there were a number of doctors and there were a few people that were from these abstinence houses. I don't recall whether it was from the Phoenix House. It was a question of trying to get some of these people employed, whether they were on methadone or abstaining.

Q Now, you are aware, of course, --

THE COURT: Are you saying that there was a panel?

THE WITNESS: Yes, a workshop.

THE COURT: I'm just not clear on that.

THE WITNESS: On this program here, they set up different panels. For example, management and labor and drugs; medical directors and drugs, There were panels of different types of individuals, different industries.

THE COURT: I thought you told me that some person or group of persons said that there was not enough known about methadone but, in any event, that methadone people should not be employed on dangerous work like driving. I think the record will reflect that. I want to know if indeed that was said and who said it.

THE WITNESS: Yes. No, that was only as far as our panel, the medical --

THE COURT: What do you mean, "our panel"?

THE WITNESS: The panel of the medical directors, not of the entire group, the management or labor.

THE COURT: It was the panel of medical directors?

THE WITNESS: Yes.

THE COURT: Who was on that panel?

THE WITNESS: I don't recall the names.

THE COURT: It was a whole group?

THE WITNESS: Yes, maybe about 14 people, the whole group of people.

THE COURT: Was there any person or group of persons who said that not enough was known about methadone?

THE WITNESS: One person who got up and summarized.

THE COURT: He summarized at the end of the discussion?

THE WITNESS: Yes, in the afternoon, yes.

THE COURT: What was his name?

THE WITNESS: I don't recall that.

THE COURT: What did he say in his summary?

THE WITNESS: Well, his summary was to the effect that methadone people were being hired in certain areas and, as I did say -- I don't know whether it was New York Life or some other insurance company or whether it was a bank, but as far as in the construction industry and in the transportation, we argued against using methadone people, so that whoever that person was who summed it up, gave both views.

I shouldn't say that they said that they didn't know enough about it. They said that it should be explored. I would rather use that term.

THE COURT: What should be explored?

THE WITNESS: The methadone, as far as the hiring of people on methadone. I shouldn't have made that statement.

THE COURT: Was anybody else there from the transportation industry?

THE WITNESS: No. No, I was the only one from the transportation industry.

THE COURT: Go ahead, Mr. Summers.

Q You are aware of the Transit Authority policy respecting the employment of persons who use or have used drugs, and there has been testimony here that the policy that the Authority does not employ persons who are currently using dangerous drugs or persons who are currently participating in methadone maintenance programs and with respect to persons with a past history of drug use the approach is an individual one. Are you aware of that policy?

A That is absolutely correct.

THE COURT: I didn't understand that there is testimony that the persons with a past history are given individual treatment.

MR. SUMMERS: I think Mr. McLaren said that.

THE WITNESS: I could testify to that.

THE COURT: No, he didn't.

What is your policy on people with past histories? Let's suppose you have a class of people to worry about, potential employees, with a past history of heroin or other dangerous drug use. Evidence would show that they are no longer on such drugs; that it is a matter of the past. What is your policy?

THE WITNESS: My policy -- what the policy of the Transit Authority is --

THE COURT: What is the policy of the Transit Authority?

THE WITNESS: Say I as the medical director, when this case is brought before me, because usually this history is taken by the doctor on pre-employment -- I do not qualify nor disqualify the man. I just make out a slip with the findings. If I found the physical findings of track marks, if they appear old, the history of how long this man has been using the drug, what type of drug he had been using, this is sent into personnel.

THE COURT: What does personnel do?

THE WITNESS: I believe it is one out of three. I don't know. Or no, I'm sorry. I do know. I was thinking of methadone. I think the policy -- I know it is the policy that they investigate the case, find out where the man has been working, how long he has been working, what his work record is, and this has been going on now for the past six or eight months.

THE COURT: What do they do?

THE WITNESS: Once it gets to personnel, I wouldn't know.

THE COURT: Let's just pause a minute because Mr. McLaren was asked by me about that very specifically and at Page 557 of the record --

THE WITNESS: Your Honor, could I add just one thing?

THE COURT: You just give me a second. You hold up.

THE WITNESS: Yes.

THE COURT: Let me just read you this. I asked the following question:

"Q Have you in recent times revised at all your policy about past drug users? As I understand it, there is some change in recent months so that you will give individual consideration to people who are now drug-free, but had drug abuse histories in the past. Is that right?

"A (Mr. McLaren:) I believe that came from a discussion that I had when I was on the stand before.

"A hypothetical question was put to me, which was:

If a person who was drug-free for ten years, free, not methadone-free, but completely free for ten years, presented himself, had no marking or anything on him, presente himself and said, 'I was on drugs ten years ago,' what would you do?"

And I said -- he must have been referring to his deposition --- "In a case like that we would look at that as an individual matter." I also made the point that I didn't think that would happen, and in my opinion at least, if there was no evidence that he had been on drugs for ten years we would hire him and no one would know about it. He would not tell us. That was the reason for that. If that should happen, the answer is yes, and as a matter of fact, the reason why we discussed this bus situation was there may be that sort of applicant in the works and we generalized the question, what we would do with a person who at one time had a history of drug use some years back, would we give consideration to that."

And then I asked:

"You would not give consideration for a bus driver position?

"Mr. McLaren: That's correct."

Now, this was a little confusing, but what I think Mr. McLaren told me wasthat they really have no policy now, at least this is the way I interpret it. They have no policy on past drug users. What they are going to do is, they will -- if they feel that they are going to get some applicants for a praticular job or application is on its way on a particular way, they will consider what policy they will adopt for that category, and he was careful to differentiate that kind of consideration from a really individual consideration, and he said for some reason they had occasion recently, in recent weeks, to consider what they would do if a past drug user applied for a bus driver's position, and he said "We wouldn't consider him," and they haven't gone through to talk about the other -- what their policy on the other positions is. They will do it when the time comes.

That is an individual consideration. That is a consideration title by title, and the question is, will they give individual consideration?

MR. SUMMERS: I can't conceive of doing it any other way because each case presents its own combination of circumstances, and you have to know them all and look at them all. That is the policy.

THE COURT: No. There is a difference. Let's get this.

THE WITNESS: Yes, but your Honor, there are some of these cases, we go as far as sending them to Dr. Trigg to decide this man has stopped using drugs or not, so that we do have a policy.

THE COURT: You are not addressing yourself to my question. We have got a lot of completely unnecessary confusion in this case because we haven't defined our terms.

Now, "individual consideration" means the willingness to consider in an individual case all the facts about that man and see if he will be hired. That's what I call "individual consideration."

Do you agree with that definition?

THE WITNESS: Yes.

THE COURT: Now, what Mr. McLaren told me was that the Transit Authority has done something different recently. They have taken up the question of whatthey will do on a particular category, that is, bus driver.

THE WITNESS: Yes.

THE COURT: So let's call that "category consideration" for want of a better term. And they have given category consideration to the bus driver position, and they have decided they will not divide consideration on the bus driver position. Is that right?

THE WITNESS: That's correct.

THE COURT: Okay. Now maybe that --

MR. SUMMERS: Your Honor, I don't see it that way. Please excuse me. But I don't see it that way.

THE COURT: The witness has just told me I'm right.

THE WITNESS: Now --

MR. SUMMERS: I'm talking about Mr. McLaren's testimony. If a person comes to you and says "I was on heroin many years ago, ten years ago, and I have had a good record since, I have thrown the habit," we say, "What job do you want?" This is one of the very significant circumstances in appraising whether you're going to hire this man.

"What job do you want?" All Mr. McLaren says, if he wants to be a bus driver, our attitude is we won't give you that job. That's all he said, I don't think we can twist it around any other way.

He did come out I think quite clear that individually the whole totality of the circumstances are considered, but if the individual wants to operate a train or a bus, we have to say no.

THE COURT: I think that's right, but you're saying it in just a different way than I was saying it. But I think that this is somewhat frustrating because I think that really the meaning is fairly plain, but we get into a semantic problem.

As far as the bus driver position, they will not give individual -- an individual consideration on whether they will hire the past drug user for bus driver. That's what Mr. McLaren is saying, is that right?

Dr. Lanzetta, that is what your policy is, is that right?

THE WITNESS: I believe that's what it is, yes.

THE COURT: So, on that category, they have an exclusionary policy.

Now, what I think he has told me about other categories, they haven't really considered. What Mr. McLaren told me is, "On the other categories we haven't thought it through. When the occasion comes up that we need to consider what we will do about car cleaners or somebody else, we will do it at that time, but we haven't had the occasion so far. So our policy on what we will do for past drug users on car cleaners and clerks and all, it is an open matter."

THE WITNESS: Yes, that is under discussion, I believe. Yes, that is under discussion.

THE COURT: All right, I believe we have the policy.

BY MR. SUMMERS:

Q Addressing yourself, Doctor, to the policy respecting persons on methadone maintenance, would you as a doctor state your reasons why you consider them -- you would not consider them for employment in Transit Authority jobs?

A Well, in my opinion, first of all, heroin was first used to take people off morphine. Now, they have methadone to take people off heroin. Now, it is my opinion, as a physician, and what I have read, that a man that goes on to heroin, there must be some deficiency somewhere. The deficiency, I may not know, but there is a deficiency.

Now, the very fact that this individual is detoxified but still needs a crutch, now, he still has to be on a drug. You have the same individual now that you don't know whether this individual now that's on methadone, if he would be under some stress or strain would not go back to heroin. We don't know whether this fellow on methadone who at one time took heroin to get high, will now go to alcohol to get high, or will go on to cocaine to get high.

You have the same individual. You haven't changed this individual at all. You have just substituted one drug for another.

Another reason why I feel we shouldn't accept anyone on methadone, now, this is simple, nd I say, I am not comparing myself with Dr. Dole or any of those experts, but from physiology in medical school, we know that the physiology of tissue has a certain chemistry. Now, when you change that chemistry of tissue, that tissue does not function normally. It wouldn't have the same function.

That's why if you have pain, and you give a shot of morphine, you are changing the chemistry of the nervious tissue the nerve endings where the pain is not transmitted.

So, in other words, you don't have a normal individual as far as nervous tissue is concerned, because that's what's involved in methadone or heroin.

Q Is methadone a --

A Another reason, again, methadone you can develop a tolerance. I honestly feel you do develop a tolerance, because if you gave 120 milligrams or 110 milligrams to a person who did not have -- who had not taken heroin or was not brought up to that tolerance, that man would be killed, he would die.

So, you're using a powerful drug. Here, you're using an addictive drug.

Q Now, how do you relate this to employment with the Transit Authority?

A Well, in the transit Authority, you have people working in the large area, and you would have to -- it would be very, very difficult to supervise these people. I mean, a man is on methadone, wants to get high, he's somewheres working out in the field, he'll go in and have a can of beer, two cans of beer, and that would potentiate the methadone.

THE COURT: It would what?

THE WITNESS: Potentiate.

THE COURT: What do you mean by that?

THE WITNESS: It would give him a high much faster than if he didn't have methadone. That's why these people on methadone, a great percentage of them, go on alcohol.

Now, if you gave methadone, mainlined it --

THE COURT: Wait a second. A man on methadone -- suppose a man is on methadone and he is working out in a yard, he's a car cleaner.

THE WITNESS: Right.

THE COURT: Now, he has a sudden desire for what you call a "high," he's had trouble with his girlfriend or something like that.

THE WITNESS: Yes.

THE COURT: He's very depressed and he wants relief from that, and he's out there, and there is nobody around, and it is dark, and he's very unhappy, so, now, he goes and gets some beer, and he has some beer with him, or something.

Now, are you saying that he -- what is going to happen to him that would be different from what would happen to some other fellow who gets depressed and wants a little relief?

THE WITNESS: Well, I think a man that wasn't on methadone -- I know -- or wasn't on heroin, and he took two beers or even three beers, I don't think he'd be high. But this man would be high.

THE COURT: You mean, he would get what we call drunk?

THE WITNESS: It would potentiate --

THE COURT: He would get more drunk faster than the man who --

THE WITNESS: I don't know what you call drunk, I don't mean he is going to fall over himself. Drunk is a question of state. He would slur, his reflexes wouldn't be as they should be.

THE COURT: In other words, the alcoholic effects would be more pronounced on him than on the non-methadone man?

THE WITNESS: Yes.

THE COURT: Why is that?

THE WITNESS: In view of the fact that his nerve tissue is not normal at this time. His nerve tissues, the chemistry of the tissue has been changed with the methadone.

THE COURT: Is this something you know from a study or what?

THE WITNESS: No, from experience of people that have been on methadone that do tell you so and do get high. A lot of them, I know, this is a matter of fact, like in the area where they financially can't afford to buy heroin, would buy a tablet of methadone or two tablets and then drink so thatthey can get high. I mean, that's a fact.

THE COURT: You mean the cumulative effect is --

THE WITNESS: You get, for example, a man taking Dilantin, which effects the nervous system and you give him a drink, and you will knock him out, you know. It potentiates the drug, or the nervous system.

THE COURT: The word "potentiates," how do you use that?

THE WITNESS: The effect of alcohol. In other words, the alcohol on a normal individual, say, who had a .5 , you wouldn't know it. If this man was on methadone, you would. That's why they go on alcohol to get high.

THE COURT: Well, is there any reason to believe that the methadone fellow is more apt to seek alcohol or other drugs than the fellow not on methadone?

THE WITNESS: Yes, because as I just stated, that you have the same individual that went on heroin. I mean, there was something lacking in this man. Something. He wasn't stable enough. You have the same individual. He's not changed.

THE COURT: Why isn't he changed?

THE WITNESS: Because he is taking another addictive drug. Why doesn't he abstain if he actually has changed, his personality, or whatever deficiency he had? Why doesn't he just abstain, say,"Well, now I am off the drug, I'm staying off the drug." Is he too weak?

THE COURT: Well,maybe he's doing the best he can.

THE WITNESS: Well, the best may not be good enough in the Transit Authority. I mean, we feel that way. You see, this is what the problem is. This is the main crux of the whole thing. If this man can't say "Well, I'm off heroin and I'm staying off heroin," which some of them do.

THE COURT: Okay.

BY MR. SUMMERS:

Q Do you see any medical similarity between a diabetic who takes insulin and a heroin addict who takes methadone?

A No, absolutely not.

Q What's the difference?

A Here insulin is needed in the body. He has a deficiency in insulin, and there again you don't have the proper chemistry in the tissue and that's why that man is sick. Now, you add insulin, and you normalize the chemistry of his tissue and he acts as a normal individual, once you balance his endocrine -- when you have an endocrine balance of the pancreas and the amount of insulin in the body to use up the sugar.

Here it is a question of replacing something. Methadone, you are not replacing, you are adding something that is not in the body or needed in the body.

Q When you say "replacing," you are replacing something in the body --

A That is lacking, that is lacking because of some illness.

Q That the body itself would normally generate?

THE COURT: In other words, you are really going back to the psychological problem. The diabetic who had diabetes didn't seek the diabetes for pleasure.

TEH WITNESS: I am not talking about the psychological problem; I am talking about the medical problem. The difference between a man getting methadone and the man getting insulin. Normally, the body should produce enough insulin, it doesn't produce it, and therefore you have to replace it.

THE COURT: In other words, insulin is putting something in the body that normally should be there?

THE WITNESS: Right.

THE COURT: And methadone is what?

THE WITNESS: Something you are adding to the body, and should not normally be there.

Q How about the comparison between the methadone patient and the epileptic?

A Well, again, in the case of an epileptic, again you are adding something there when you are adding Dilantin, and that is to prevent the excitability of the brain. It is a sort of a sedative action rather than a narcotic action, so that you don't get epileptic seizures.

Q What is your overall view, Doctor, of the comparative value of chemical maintenance for a drug addict like the use of methadone and a program which requires abstinence, such as the therapeutic program conducted by Odyssey Houses and Phoenix Houses that you mentioned? Give me your overall view.

A Yes. I think overall, if we are to treat these drug addicts we ought to treat them and not substitute any other medication.

In other words, we ought to treat these addicts to the point where they will abstain.

Q Similar to AA programs? Is that what you have in mind?

A That's correct.

MR. SUMMERS: That's all for now.

THE COURT: Is that all you have?

MR. SUMMERS: Yes, I'm finished with the witness now.

THE COURT: All right, let's have the cross examination and I may have some questions after that.

CROSS EXAMINATION

BY MR. BALBER:

Q Dr. Lanzetta, you stated that you interned at Metropolitan Hospital?

A That's correct.

Q What year was that?

A 1933.

Q Was that a rotating internship?

A That's correct.

Q And what does a rotating internship mean?

A Well, medicine, surgery, orthopedics, ear, nose and throat, and we had this ward, just one ward for the detoxification, I was on T.B., generalized, general practice, let's put it that way.

Q And you interned for one year?

A That's right.

Q So that year was divided up among all those different services, is that correct?

A Well, the other services, like, for example, ear, nose and throat, where I would not be interested, I could forego them and take medicine or surgery.

Q How much time did you spend dealing with drug addicts during your internship?

A I would say a period of one month.

Q And what method of treatment was used at Metropolitan Hospital?

A Well, at that time they were using barbituates to detoxify, try to get them off morphine, at that time it was not morphine, it was heroin.

It was morphine, and they were giving them sedatives which would be chlorhydrate and phenobarbital, but there was absolutely no success. They did close the ward.

Q That wasn't a methadone maintenance ward, was it?

A No, no, methadone was nowheres near at that time.

(Continued on next page.)

Q Doctor, you also stated that you had a practice in East Harlem; is that correct?

A That is correct.

Q And that you knew many drug addicts when you were in East Harlem; is that correct?

A Yes,many drug addicts came into my office; that is, their family or they.

Q Isn't it a fact that you never in your life have treated a drug addict?

A I didn't say I treated. I say I saw drug addicts. I didn't say I treated drug addicts.

Q What did you do with these drug addicts when you saw them?

A First of all I have to examine them. A person would come into my office and would give me classical signs of kidney cholic. I would examine that individual and I would notice that the fellow had track marks. Immediately I knew what he wanted, you see, and then I would get to talk to him and he would admit that he was a drug addict.

Now, most of these people, I would advise them at that time -- I think it was before the methadone program. I think there was Knickerbocker Hospital was detoxifying drug addicts and also there was a private institution, Townes Hospital.

Q These were short-term detox programs?

A I don't know how long those programs were. I just would refer them . One was a Townes Hospital and I believe the other one was -- I'm not so certain, but I think Gracie Square Hospital also did detoxification at that time.

You are going back now long before the methadone program.

THE COURT: In your practice in East Harlem you saw a lot of drug addicts; is that right?

THE WITNESS: That is correct. I saw a number.

THE COURT: I'm not sure what you said, but what would you do when you saw them?

THE WITNESS: All right. For example, just let's be very frank about this: At the beginning I was trying to help these people and before I knew even -- when Dorinden first came out that was an addictive drug. When it first came out it was given as a hypnotic for people who could not sleep. Now, a lot of these drug addicts would come to me and say, "Doctor, I'd like to get off this drug."

I would get the mother or -- they wanted to get off heroin.

THE COURT: You are talking about heroin?

THE WITNESS: Yes.

THE COURT: What does Dorinden have to do with it?

THE WITNESS: I am going to come to it. So I'd have one of their parents or a wife and I would explain.

THE COURT: "All right, you've got to go cold turkey."

THE WITNESS: I would prescribe Dorinden but the wife would have to have the vial. You know, so as to --

THE COURT: What would you prescribe Dorinden for?

THE WITNESS: It was because it was a hypnotic. A man could sleep because he was on heroin and it did relieve him of some of the withdrawal symptoms. But this didn't last long because then the literature came out that Dorinden was more addictive than some of the other drugs. Then, of course, I stopped it completely. Now it is in the controlled drugs, but when it first came out it was used as a hypnotic for people who weren't able to sleep.

THE COURT: Then after that what would you do in other ways?

THE WITNESS: All right. I tried to send a few people to Dr. Baer.

THE COURT: How did that work out?

THE WITNESS: I wouldn't say it didn't work out well. Then, when the methadone program started, of course it was very difficult. When it first started these methadone centers, because they had quite a waiting list -- then I advised some of my patients to go on methadone because of the fact that they were getting into a lot of trouble; the fact that the family would come over crying as to what their children were doing. So I tried to help them in that way.

THE COURT: Do you know about how many people you recommended to go on methadone?

THE WITNESS: I would recommend it, but they never would get on the methadone program at that time before 1970. I think it opened up where you could get in so easily way after 1970.

Whoever came in and wanted help. If they wanted drugs, that was out. I would no longer give them, because it got so that these drug addicts knew more about Dorinden than I did.

THE COURT: There came a time when you knew about methadone maintenance, did there not?

THE WITNESS: Yes.

THE COURT: Did you recommend to some people to try to get on the methadone program?

THE WITNESS: Yes, maybe 30, 40 people.

THE COURT: Did any of them get into a program?

THE WITNESS: Well, two of them positively at the very beginning. I remember their names, and just before I stopped my practice another boy who had been a drug addict for quite awhile had gone on the methadone program.

THE COURT: So that is three people?

THE WITNESS: Wait. But there are a number of them that went on the methadone programs, but then would go off it, you know, and would come back.

THE COURT: I just wanted to know. You just mentioned a total of three.

THE WITNESS: These three that I sort of kept track of, you know, that I knew them fairly well, their families. They had been --

THE COURT: Were there any others aside from those three, to your knowledge, whether you kept track or not, who actually got into a methadone program?

THE WITNESS: No, I wouldn't know whether they did. A lot of them were taking methadone, but I don't believe they were on a methadone program. A lot of them were getting methadone from doctors at that time.

THE COURT: Now, on these three that you followed, how did they work out?

THE WITNESS: Well, two of them were very bad and the other one, of course -- the last time I saw him, he was on the methadone program. He was a young boy, so I don't know what happened after that.

THE COURT: What do you mean? What happened with the two of them?

THE WITNESS: One of them.

THE COURT: What programs did they go into?

THE WITNESS: One of them was in the Rockefeller Program and we started and also I spoke to Dr. Trigg. He remembered this boy. Lane was his name. I think it was.

THE COURT: You mean the Rockefeller Institute?

THE WITNESS: Yes.

THE COURT: Who was administering that program?

THE WITNESS: Dole; it was Dr. Dole.

THE COURT: What specifically happened?

THE WITNESS: Eventually he was killed. He became a real drug addict, a pusher. He would go on the program, go off, go on, go off, so he eventually --

THE COURT: This was the one man whose name you gave me?

THE WITNESS: Yes.

THE COURT: What about the others?

THE WITNESS: The fellow Russo, which was his name, I knew the family. I had a couple of incidents with this boy. He had been back and forth on the methadone program. Exactly where, I don't know.

THE COURT: When you say on and off the program, you mean going from methadone to heroin?

THE WITNESS: Yes, they were going back to heroin.

THE COURT: So the second one was off and on in that way?

THE WITNESS: That is correct.

THE COURT: What eventually happened to him?

THE WITNESS: One night I saw him. He just flopped in my office, you know, wanted me to give him injections. He had withdrawals. I told him to go or I'd call the police. He was in bad shape. His family -- I knew the boy.

THE COURT: And the third man?

THE WITNESS: The third was a boy. He was a young boy. He came to my office.

THE COURT: What program was the third one on?

THE WITNESS: He was among the methadone program. I didn't ask him, but I think he was in on the recognized methadone program. But I think that may be a week or two before. I knew him as a drug addict, a young boy about nineteen, I think, twenty. When he came in I was surprised because he was so young. He told me he got on the methadone program. I told him to stay on it.

THE COURT: How did it work out?

THE WITNESS: I say I didn't follow it.

THE COURT: You didn't follow it?

THE WITNESS: No.

THE COURT: Okay, I'm sorry, Mr. Balber.

Q You stated that you recently went to a conference run by the Bureau of Narcotics & Dangerous Drugs; is that correct?

A That is right.

Q At the Commodore Hotel?

A Yes.

Q Is the Bureau of Narcotics & Dangerous Drugs a drug treatment agency?

A Yes, I think it is a State -- I think it is the State, if I'm not mistaken, but I met someone there who worked for them. I think he worked -- it was from the State.

Q Doctor, isn't the Bureau of Narcotics & Dangerous Drugs a Federal Law Enforcement Agency?

A Yes, it is. It is a law enforcement agency. That is why I felt -- that is the one I went to in February. I know that is actually so because I have it here.

Q You stated you had a workshop at that seminar run by the Bureau of Narcotics & Dangerous Drugs and people said that persons who are on methadone should not be employed in hazardous situations. Who, exactly, said that, doctor?

A I said that. He didn't say it himself.

Q Who said it?

A He said -- they were giving a summation of what went on in the different seminars, the workshops.

Q Who made the summation?

A One of the doctors.

Q Who was that doctor?

A I don't recall.

Q Do you know what company he worked for?

A I couldn't tell you who he worked for. I think it was --

MR. SUMMERS: I object to the question.

THE WITNESS: Names to me didn't mean anything.

MR. SUMMERS: He said on direct examination he didn't know the name of the doctor.

THE WITNESS: I'm just bringing out the facts.

MR. SUMMERS: What is the use of asking him about it?

THE COURT: He said that. You don't need to go into that.

MR. BALBER: Okay.

THE COURT: Isn't it correct that that doctor who summarized was just repeating on that subject what you and the union man had said?

THE WITNESS: Yes, sir, that is right, what was said at that workshop.

THE COURT: By you and the union man?

THE WITNESS: No, because he said, someone in that workshop said that these men could be employed in certain areas.

THE COURT: But on the employability --

THE WITNESS: That is right. It was what I said and what the union man said.

THE COURT: All right.

Q Doctor, you stated that methadone has an effect on the physiology of tissue.

A Right.

Q On what do you base that statement?

A Well, it is a very simple -- just physiology. In other words, all tissues or different tissues are chemically set -- right? -- As a balance. If you add something to that tissue it is no longer balanced. So, therefore, it cannot react normally.

I will give you an example: In physiology we have muscle tissue. When we would stimulate muscle, you will get a contraction.

Q When did you do that?

A In medical school. Then we'd add, for example, calcium and put it into a calcium solution. There you would get a tetany, a different type of contraction, a more violent contraction. In other words, a contraction -- this would be a contraction and the tetany would be such a fine vibration there. There is a marked contraction. So that what I'm talking about is physiology.

Now, I'm not talking about whether it is methadone or aspirin. You have a headache and you relieve it with aspirin. You are changing the chemistry, I mean, because you get relief for that headache.

Q Then aspirin also affects the tissues?

A What?

Q Is that what you are saying?

A Any drug would affect the tissues.

Q Including antibiotics and aspirin?

A Antibiotics definitely affect the tissues.

Q Are Transit Authority employees allowed to use aspirin?

A What is that?

Q Are Transit Authority employees allowed to use aspirin and antibiotics?

A Yes.

Q Tell me, doctor, what specific effect does methadone have on the tissues besides the effect that it generally affects the tissues, as all drugs do. Specifically what does it do?

A Again, I'll have to speak specifically. I attended a seminar at the South Oaks Hospital near Amityville. I don't know if you know it. It is a psychiatric institute. It was a two-day seminar on drugs. Of course, after the talk I went to speak to this neuropathologist and asked him about methadone, what effect, you know, it would have on the nervous system and the tissue, and he claimed or stated that there is some brain deterioration over a long period of time of using methadone just like you would with amphetamene.

Q Where was this doctor from?

A South Oaks Hospital.

Q That is where the conference was held. Where was this doctor from?

A You see, again, he is one of the professors there. He may be the neuropathologist at South Oaks.

Q What research had he done in the field of methadone maintenance?

A He is one of the top men, I believe. I read the --

Q He is one of the top men, but you don't remember his name?

A No, if I tried to remember the names of every article I read by doctors, I just couldn't do it, not at this stage anyway.

Q Did he state to you what the basis for his conclusion was?

A No. He just said these were his findings on autopsy.

Q On autopsy.

Doctor, you stated that you are opposed to methadone because it is added to the body and it is somewhat unnatural; that the body doesn't generate it;

is that right?

A Yes. it doesn't generate methadone, no.

Q You said dilantin was all right. Now --

A I didn't say dilantin was all right. What do you mean? I just said that dilantin was used and it did affect the nervous system and it was in the tissues. It was not a narcotic. It was a sedative.

Q Dilantin affects the tissues and affects the nervous system; is that right?

A Yes.

Q Does it affect the brain?

A Yes, it becomes -- it prevents a convulsive seizure.

Q Is dilantin the standard drug used in the treatment of epilepsy?

A Yes.

Q Hasn't the Transit Authority hired epileptics?

A Not in the operating area, we do not.

Q But you will consider them for some positions in the Transit Authority?

A Some positions, yes, but not in the operating area. And then again, it is the individual case. Now, again, you just bring up a subject. Has the man been free of epilepsy for five years? Has he been under constant treatment? We get letters from --

Q What do you mean free of epilepsy? Isn't epilepsy a permanent condition?

A When it starts we don't know because if the man is on medication -- first of all, epilepsy, you are going into a subject -- all epilepsy is pschomotor seizure. If you are talking about ideopathic epilepsy, you can have epilepsy from an alcoholic with a wet brain, if that is what you are talking about. I don't know what you are talking about.

Now, there is ideopathic epilepsy. There is Jackson epilepsy. There is epilepsy due to wet brain.

Q I'm talking about epilepsy treated with dilantin.

A They are all treated with dilantin.

Q What happens if you stop taking the dilantin when it has been prescribed? Can't you go into convulsions? Can't you go into seizures? Isn't there a danger that the person will not function properly, doctor?

A Yes, that is why we don't put them in operating areas. Exactly right.

Q But you will employ them as clerks, as stenographers, as secretaries, as administrative assistants?

A Now, it is --

Q Isn't that correct, doctor?

A Give me a chance to answer the question.

Q Is that correct?

A It all depends on the individual case.

Q You will consider them individually?

A I have put an epileptic on as a clerk, yes.

Q Doctor, do amphetamines affect the tissues?

A Of course they do.

Q Do they affect the central nervous system?

A Absolutely.

Q Do they affect the brain?

A Absolutely.

Q Haven't you given permission to Transit Authority employees to use amphetamines?

A Have I given permission?

Q Yes.

A No.

Now, you know, you asked a question. You don't give me a chance to explain. Now, for example, I have found amphetamines in an employee who works for us. He is a bus operator. It was prescribed by a doctor. First of all, the man didn't look like he was overweight to me, so I called up the doctor and told him if he didn't discontinue the amphetamines I would take him off the bus. I would not allow him to drive it because he is taking amphetamines.

Q What do you mean you would take him off the bus? What would you do with him?

A I'd put him on restricted duty, some other duties.

Q Would you recommend that he be suspended from work permanently?

A This drug --

Q Would you recommend that he be fired?

MR. SUMMERS: I object to counsel interrupting when the witness is trying to give an answer. He should be permitted to answer.

THE COURT: We are getting a little excitement with this trial. Let him finish. He is trying to respond. You wait for Mr. Balber to finish his questions.

THE WITNESS: All right.

THE COURT: Okay, go ahead.

You ask him questions.

Q My question is: You said that you would recommend that he be taken off the bus.

A Yes.

Q But do you mark him no work permanently?

A I didn't say I would mark him no work permanently.

THE COURT: That is the question. You listen to his question and answer it.

THE WITNESS: I can't answer it yes or no because in this individual --

THE COURT: Answer it first and then make your explanation.

THE WITNESS: All right. I don't mark him no work permanently, but I would ask him to stop using the drug if I feel the man does not need the drug and he is not overweight, although in my opinion I don't think amphetamines do help in the reduction of weight, but in view of the fact that the doctor prescribed it I am not going to argue with the doctor as to what he prescribes. But if I feel that this man is of a normal weight, I will tell him that he will be checked and he has got to stop the amphetamines. If he is, then he will be brought up on disciplinary procedures.

THE COURT: Are there instances where you will permit people to be in an operating position and who use amphetamines if it has been prescribed and if you feel that the man is overweight; will you permit that?

THE WITNESS: No, because I have spoken to the doctors in most of the cases and I have spoken to the doctors in most of the cases and I have spoken to the individuals, because I believe -- you know, amphetamines are a controlled drug and I feel if you read the literature, that amphetamines do not absolutely let you lose weight. In order to lose weight with amphetamines -- it is just a hoax. Maybe the first week, but now if you can lose weight you got to increase it to two capsules. The next week then to three capsules. I found that in my own practice when I didn't know what was happening. You only learn from experience. I had a patient who was overweight and I gave her dexadrine. She lost the weight. Then she wanted some more dexadrine. I told her, "You don't need any.

"Oh, but it makes me feel wonderful when I take it.

"Oh, you don't need it."

That is what I'm trying to bring out. But now in the literature definitely it is a diet that will take the weight off, not amphetamines.

THE COURT: We will take a short recess now.

[Recess.]

Q Doctor, I think we were on the subject of the tissues. I would like to turn to that.

A Could you come up close? I can't hear you.

Q You stated earlier that methadone potentiates the alcoholic action of beer, is that correct?

A I said alcohol potentiates the methadone. In other words, a man will get a high if he is on methadone and takes alcohol.

Q Will a man get a high if he drinks alcohol and isn't on methadone?

A No, not as easily.

For example, two beers, which would amount to two ounces of whiskey --

Q Right.

A -- ordinarily you wouldn't expect a man to be high on two scotch and sodas, but you will get high if you are on methadone.

Q It's an alcoholic high, is that what you're saying, Doctor?

A I'm not saying, no. How can you say an alcohclic high. If a normal person wouldn't get the alcoholic high.

Q What is it, Doctor, is it as though the person on methadone takes two things he might as a normal person who took six drinks, or what are we talking about here? What happens?

A All I'm saying is that the man that's on methadone who takes two drinks, may slur, whereas the average individual who is not on methadone will not slur or will not be high.

Q And is slurring a symptom usually associated with drinking?

A Yes, the amount though.

Q So what you're saying is that the person on the methadone might be a little more sensitive to alcohol?

A A lot more sensitive.

Q A lot more sensitive. What basis do you have for that opinion, Doctor? What studies are you relying on?

A What studies?

THE COURT: He asked two questions now. He may have a basis, but he hasn't made any studies.

THE WITNESS: Observation.

Q Observation of who?

A Some of these patients of mine that were on methadone.

Q Doctor, you stated that you had two patients on methadone that you followed. When did you observe them?

A When did I what?

Q When did you observe them drinking?

A I have observed them drinking, but that's not the only thing. I have read --

Q What have you read?

A I have in articles where alcohol potentiates a person taking methadone.

Q Who wrote these articles?

A Well, if I were to repeat every article I read, I mean, there are just too many articles. There isn't an article that deals with drug addiction or methadone, you know, that I don't peruse through.

Q Can you name -- of these many articles, can you name one author?

A I can't think of a name.

Q Can you remember the title of one of these articles?

A Yes. Well, "The Effects of Methadone." There have been articles written on the effects of methadone, and I have read those articles. I have read articles on the effects of heroin.

Q Were these scientific articles, Doctor?

A Absolutely. I read nothing but the medical jo journals.

Q And they explain the physiological interaction between alcohol and methadone and what that does to the body, is that right?

A Not the physiological. They state emphatically that when a man is on methadone and takes alcohol, the same as when a man is on -- what is that other drug you mentioned on epilepsy, takes alcohol, they get high.

Q A man on methadone acts like the epileptic on Dilantin, is that what you're saying, when he drinks?

A When he drinks, yes.

Q Doctor, what was the chemical basis, the physiological basis for the conclusions reached in these articles? The conclusions you just stated?

A Well, the conclusions would be from, as I say, observation or reading. Why, at one time, when you took sulphur, they added penicillin with sulphur because it would potentiate the sulphur.

Q We are not talking about sulphur.

A It's the same with organisms. You get organisms in the mouth. There are some bad and good. If you remove sometimes the bad, some other organisms will grow in that area. So there is a synthesis or potentiality. Exactly the physiology of it, or the chemistry of it, I may not be able to explain, but it does occur.

THE COURT: Did you say that the epileptic drug--

THE WITNESS: Yes, Dilantin.

THE COURT: Dilantin, yes. If a person on Dilantin took alcohol, the alcoholic effects would be exaggerated in the same way as the situation with the methadone?

THE WITNESS: Yes. Definitely. Definitely.

Q Doctor, are you familiar with a drug called Darvon Compound?

A Yes.

Q Darvon Compound 65?

A Right, I do.

Q That drug is commonly prescribed for toothache?

A Right.

Q And things of that nature, right?

A That's correct.

Q Are Transit Authority employees permitted to use Darvon Compound 65?

A Yes, if it's prescribed by a physician. First of all, it is not a controlled drug.

Q I take it it is a relatively mild drug?

A Yes, that's right.

THE COURT: What's the name of the drug?

MR. BALBER: D-a-r-v-o-n Compound 65.

A It's not much stronger than aspirin, actually. There are different sizes, 65.

Q You say it's about as strong as aspirin?

A A number of doctors say its effect is not very much more. First of all you don't develop a tolerance to Darvon. You don't become addicted to Darvon. It an analgesic.

Q And isn't it true, Doctor, that Darvon potentiates the action of alcohol?

A Darvon potentiates -- that I have not heard.

THE COURT: What's an analgesic? How do you spell it?

THE WITNESS: A-n-a-l-g-e-s-i-c.

THE COURT: What is an analgesic?

THE WITNEWS: It's a pain killer, not actually -- suppress pain, let's put it that way.

THE COURT: Now, you're talking about a family of drugs when you're talking about analgesic, right?

THE WITNESS: Yes, they are a family, like aspirin would be an analgesic.

THE COURT: Is methadone the member of some family?

THE WITNESS: Well, that's a narcotic.

THE COURT: Is that a technical family name?

THE WITNESS: Yes, because there you develop a tolerance, and you get withdrawal symptoms. That's what differentiates it from Darvon. You would not get withdrawal symptoms. You would not develop a tolerance for it. You do not get a high.

THE COURT: How would you associate the development of a tolerance with withdrawal symptoms? I'm not clear about that.

THE WITNESS: No, no, no, I said these are two different things. In other words, with methadone, if you were to stop methadone, you would get withdrawal symptoms. Whereas, a --

THE COURT: Is that the same thing as developing a tolerance?

THE WITNESS: No, it is not the same thing. In other words, if you want, say heroin -- say you take one shot a day and it makes you feel good. Well, tomorrow you may need zwo shots to feel as good as you did yesterday. That's the development of tolerance.

THE COURT: That's the problem with tolerance.

THE WITNESS: That's right.

Q Doctor, isn't methadone also an analgesic?

A It is not considered that. It is considered a narcotic. It kills pain.

Q Hasn't it been used for treatment of cancer patients for example, to relieve pain?

A Yes, but it is also --

Q Isn't morphine also used to relieve pain?

MR. DUNN: I object to the witness being interrupted continuously.

THE COURT: Let him answer. Right.

A When we talk about analgesics, you would never give morphine except in excrutiating pain, something of that sort. Whereas Darvon or aspirin would be an analgesic. We place the morphine, the Demerol, in the narcotic group rather than the -- although you get an analgesic effect, let's put it that way, but it is not an analgesic.

Q Doctor, earlier in your testimony when you were talking about the basis for your methadone policy, you said that you talked to Dr. Gollance, Dr. Trigg?

A Right.

Q And Dr. Baird?

A Right.

Q Now, wasn't Dr. Baird at one point hired as a consultant to the Transit Authority on drugs?

A That's correct.

Q To what extent did you rely on Dr. Baird in the formulation of your policy?

A I didn't rely on him, on the formulation of the policy. Absolutely not. He gave me his opinion. He maye have given his opinion.

Q Did you seek out his opinion on methadone?

THE COURT: You better take it easy.

MR. DUNN: Your Honor, I object.

THE COURT: You're interrupting the witness.

Q Go ahead, answer.

THE COURT: Not clear, Dr. Baird was once a consultant for the Transit Authority?

THE WITNESS: THat's correct.

THE COURT: For what purpose?

THE WITNESS: When we had cases that were suspected of drug addiction, we did not get a positive urine, say, for morphine, but I thought I found maybe that these people were snorting, then I would send them over for consultation to get his opinion, whether they were using drugs or not.

THE COURT: Just on the question of fact, right?

THE WITNES: That's correct.

Q Did you seek out Dr. Baird's opinion on methadone maintenance?

A Yes, I know Dr. Baird's opinion on maintenance.

THE COURT: He asked you if you sought it out.

THE WITNESS: I know his opinion, because I have discussed this a number of times with him,

THE COURT: Did you rely on that opinion?

THE WITNESS: No, I did not rely on it.

THE COURT: What was his opinion?

THE WITNESS: His opinion, he was definitely -- he definitely felt that the methadone, you were just making methadone addicts, and you were not changing the individual and that the only way to treat an individual is to get him to a point where he would abstain.

Q Doctor, have you relied on anyone's opinion?

A Yes. No, not one. For example, I called up Dr. McCoy who was the chief of the New York City Police Department to get his opinion at that time. I think it was in 1970. And he definitely stated they would not hire any methadone addicts or drug addicts.

I spoke to the physician in charge of the City Prisons, Department of Corrections.

I spoke to the physician in charge of the State Police.

I spoke to the physician in charge of the State Correction Department.

I spoke to Dr. -- now, all these people that I have just mentioned, of course, would not hire any drug addicts or methadone addicts.

Q Had any of them had any experience with methadone maintenance treatment?

A Let me finish first.

Q Go ahead.

A I spoke with Dr. Cimino who atthat time was doctor in charge of Sanitation and he stated he was starting a pilot program on methadone. But I asked him what these people would do and he of course said he would not permit them to drive, and they would do other work, I guess, collecting trash, collecting it into a can. Then I spoke to the doctor in the Hospital Department, Department of Health, and they both said they were hiring methadone people.

So that I got a cross-section. I didn't just decide.

Q So you relied on their opinions, is that it?

A I just wanted their opinions. And then when I spoke, for example, to the --

Q Did you rely on their opinions?

A I just wanted facts.

Q You stated you haven't relied on Baird's. Have you relied on --

A I didn't rely on anyone's opinion. I just took in all the facts. Whatever facts were given. For example, when I spoke to Dr. Cimino and he said he was hiring people on methadone, I asked him just what they did. When I spoke to--

THE COURT: Who is Dr. Cimino?

THE WITNESS: Dr. Cimino at that time was Commissioner of Sanitation and he stated he would not permit them to drive a vehicle and they would only be used to throw the trash or garbage into the truck. I spoke to the head of the Hospital

Department, I forget who it was, one of the doctors there, and he said they hired methadone people, and I asked him point blank, wasn't it kind of dangerous where you have drugs and you know, to have a man on methadone, he said, "Well, they were very careful not to put him in sensitive positions."

And the same thing with the Department of Health. But they hired them. So all I wanted was facts. I didn't want any one to tell me what to do.

Q Doctor, are you a member of the New York State Industrial Medical Society?

A Yes. It is now no longer the Industrial Medical Society, it's been changed this year to the American Occupational Medical Association. I stated that. This year. They changed their name.

Q And who is the President of that society?

A Believe it or not, I don't know. I honestly don't--

Q Is the President Dr. Doyle? Does that ring a bell?

A Dr. Doyle, I know Dr. Doyle well. I know him from when we first -- I met him about five years ago. I had a program or spoke about our program before they had a program. I know Dr. -- in fact, I called him, just a few days ago, I wanted to know about his program.

Q Didn't you call -- you said you called him a few days ago?

A No, I wouldn't say a few days, I would say about a week ago.

Q About a week ago. And Dr. Doyle is medical director of Con Ed, is that right?

A Of Con Ed.

Q And isn't it true that you called Dr. Doyle and asked him for medical evidence to support the proposition that people on methadone should not be employed in hazardous positions?

A I did not say that.

I just asked him if he was employing people on methadone. He said yes.

I says "How many people do you have on methadone"

He says, "One hundred."

I said, "How many people do you employ?"

"20,000."

That's a kind of small percentage to me to come to any conclusion.

Q Isn't it true, Doctor, thatyou asked Dr. Doyle if it wasn't true that methadone effected the tissues and that people on methadone shouldn't work in hazardous situations, and that Dr. Doyle told you that his experience did not in any way support that proposition?

A No, no, no. First of all, I discussed methadone and drugs with Dr. Doyle, because he attended every seminar that I have been to, so I know him very well. And I may have discussed with him my opinions, and I don't recall his opinion, I don't know how well you know him, but he is the silent type.

THE COURT: He's the what type?

THE WITNESS: Silent type. So, I couldn't get very much from him as to his opinion.

I gave him my opinion.

MR. BALBER: Your Honor, that concludes cross, unless I want to follow something your Honor might have.

THE COURT: Any redirect?

MR. SUMMERS: No, your Honor.

THE COURT: All right, you may step down, Doctor.

I do want to ask you -- I meant at the recess to -- show you some findings of fact proposed by the plaintiffs about the policy on alcoholics. Maybe we can hold you on the stand for just a moment.

THE WITNESS: Yes.

THE COURT: Mr. Summers and Mr. Dunn, could you look at the black book, Exhibit 31 for identification. Could you look at page 61?

We will go back to 60. Now, at the bottom of page 60, there is the statement: "Plaintiffs have submitted the following finding, 50 and 51."

Now, apparently you came back and you substantially agreed with them that you had your language, and then the plaintiffs now propose their language.

The difference, it seems to me, are rather narrow. I wish we could get -- if we could find out to what extent you will agree with the language that the plaintiffs have at the bottom of 61 and all of 62.

I don't see any particular reason for bothering Dr. Lanzetta with detailed testimony about their policy on alcoholics if it can be agreed upon, but if it cannot, I think he ought to be asked.

MR. SUMMERS: Are you waiting to hear from me, your Honor?

THE COURT: Yes, I am.

MR. SUMMERS: The plaintiffs have taken our statement as to what happens for a violation of Rule 11A and they have substituted their version of it, which we don't agree.

For instance, most of the --

THE COURT: Then why don't we -- are you familiar with the Transit Authority's policy on alcoholics?

THE WITNESS: Yes.

THE COURT: Could you do this for me, could you take some language: At the bottom of page 61, and over on 62. Could you take a few minutes and read this, don't pay any attention to the brackets, or any complication, just read through and you tell me whether it is correct or incorrect.

If it is incorrect, you correct it.

Can you do that?

THE WITNESS: Yes.

MR. SUMMERS: May I have a sort of a voir dire here? I'd like to ask the witness whether or not you are thoroughly familiar with the Authority's policy respecting disciplinary measures taken against employees who violate the rule against use of alcohol?

THE WITNESS: That I wouldn't know. That I would not become involved in. The only time I become involved in the alcoholics is when there is some complications to the alcoholic.

BY MR. SUMMERS:

Q You're familiar with the medical aspects?

A The medical aspect, that's correct. Not disciplinary action. I have nothing to do with the disciplinary area.

MR. SUMMERS: I submit he is not qualified.

THE COURT: Who is?

MR. SUMMERS: I can bring somebody here within an hour.

I really don't think Dr. Lanzetta or anybody else should have to testify. It seems to me that there could be an agreement on what is done about alcoholics and --

MR. SUMMERS: Who knows better than we what we do, and we stated it. They substituted their own language. We stated it. If they don't accept it, I can't help it. We will have to put on a witness to prove it, that's all.

THE COURT: Just easy there.

If they are wrong, obviously you shouldn't agree. But just because it's their language doesn't mean that they are wrong. Maybe they have expanded it beyond what --

MR. SUMMERS: They have changed it, your Honor, completely, not expanded it.

THE COURT: Are they wrong?

MR. SUMMERS: Yes, definitely.

THE COURT: Are you prepared to go through and point by point explain in what way they are wrong?

MR. SUMMERS: Yes.

THE COURT: Okay. We don't need Dr. Lanzetta for that.

MR. SUMMERS: No, he is not familiar with the problem. But neither am I an expert, but I think I know what it is.

THE COURT: Okay. That's fine. We are finished with you. Thank you.

(Witness excused.)

* * *

Dr. Vincent de Paul Lynch
Professor of Pharmacology
Chairman, Department of
Pharmaceutical Sciences
Director, Division of Toxicology

BIOGRAPHICAL SKETCH

Vincent de Paul Lynch, Ph.D.: B.S. (N.S.) Niagara University (1950)/ B.S. (Pharm.) St. John's University (1954); M.S. (Pharmacology) University of Connecticut (1956); Ph.D. (Pharmacology) University of Connecticut (1959). Research Fellow (Pharmacology) Connecticut 1954-56. Graduate Assistant, Connecticut 1956-58. Assistant Professor, St. John's University 1958-61. Associate Professor 1961-66. Professor 1966--. Chairman, Department of Pharmacognosy, Pharmacology and Allied Sciences, 1961-1973. Director, Division of Toxicology 1969-1974. Chairman, Pharmaceutical Sciences Department 1973--. Member: American Association Colleges of Pharmacy; American Society Pharmacognosy; American Association University Professors; Sigma Xi; Rho Chi; International Society of Psychoneuroendocrinology; International Narcotics Officers Enforcement Association. Consultant: N.Y.S. Joint Legislative Sub-committee on Drug Abuse; N.Y.S. Drug Abuse Control Commission. Listed in: American Men of Science, Who's Who in America, Dictionary of International Biography. Editor of the Section of Pharmacology of PDM (International Congress of Pharmacology).

New York State Certificate No. 843

Controlled Substances Registration Certificate

Schedule 1	PS0018021
Schedule 2,2N,3,3N,4,5	AL0779871

* * *

VINCENT DE PAUL LYNCH, called as a witness by the defendants, being first duly sworn, testified as follows:

DIRECT EXAMINATION

BY MR. DUNN:

Q Dr. Lynch, did you prepare a biographical outline?

A Yes.

Q Did you send it to me this morning?

A Yes.

Q And does this outline accurately reflect your qualifications and experience?

A Yes, it does.

MR. DUNN: I would like to offer this.

(Defendant's Exhibit I, marked for identification.)

THE COURT: It is received.

(Defendant's Exhibit I, received in evidence.)

Q In addition to the qualifications, Dr. Lynch, does that show on the biographical sketch that you prepared, are you qualified to teach and do you teach certain courses?

A Yes, I do.

Q And will you name those courses for me, please?

A I teach one course in general pharmachology. I teach a course in pharmachology of the central nervous system, pharmachology of the autonomic nervous system and pharmachology of drug abuse and I also teach a course periodically in biostatistics.

Q Now, Doctor, we have been dealing with terms in this case, and I would appreciate if you could define various terms for us. Could you define the term "narcotic?"

A Yes, technically speaking a narcotic is a substance that will cause you to go to sleep. This is a definition they use in law.

Q Now, is methadone a narcotic ?

A Yes, it is.

Q Can you explain for us as simply as possible what effect, if any, a narcotic has on the human body, including the brain?

A Generally speaking, narcotics produce initially in therapeutic doses a degree of sedation, which would be produced by central nervous system, depression, depression of the brain, if you will, and because of this depression there will be other so called peripheral effects in other parts of the body in addition to the brain.

THE COURT: Initially there is the effect of sedation?

THE WITNESS: Yes.

THE COURT: And causes what on the brain?

THE WITNESS: Because of the sedative effects in part there are other depressant effects that appear on other parts of the body.

Methadone in particular is said to have little or no effect on circulation, but because of the initial sedation, you will see a dilation of blood vessels in the skin of the neck and the back. This is something that goes away rather quickly in a person who uses the drug frequently.

But you will also see smooth muscle depression, this is one of the causes for, as a matter of fact, in part the constipation that accompanies the use of methadone and many of the other opiate compounds, methadone is a member of that class.

The central effects are rather difficult to explain. The effects on the brain. The drug undoubtedly occupies receptor sites, and it disrupts the effect or neurons transmitting impulses in the brain. Now, some of these -- some of the neurons are involved in the cerebral cortex, and that would effect cognative faculties, the ability to respond voluntarily in certain situations.

But also, there must be some kind of an involvement with other parts of the nervous system and not the so called cognative faculties.

When we talk about the nervous system, we talke about a central nervous sytem and we talk about what is known as an autonomic nervous system. The central nervous systme is that part of the nervous system over which you can exert some degree of will, the motor functions and the sensory functions are a part of this.

Now, there are other parts of the nervous system, this other part of the nervous system, the autonomic nervous system, is a part over which you cannot exert voluntary power. This is a part of the nervous system that controls blood pressure, respiration, heart rate, smooth muscle activity in the stomach and the intestines and other areas of the body.

So, we don't -- the function of methadone insofar as nerve activity is a very complex one, and as a matter of fact -- undoubtedly some of the effect that we see, I think in nausea and vomiting, that is caused by in some patients, by methadone, is due in part to this imbalance in the autonomic nervous system.

THE COURT: Are you saying that methadone creates an imbalance in the autonomic nervous system?

THE WITNESS: Yes.

THE COURT: How do you speall autonomic?

THE WITNESS: A-u-t-o-n-o-m-i-c.

THE COURT: What happens as a result of that imbalance?

THE WITNESS: Well, a variety of different things. I say in some instances it produces nausea and vomitting. In some cases it will produce minor effects with respect to respiratory activity.

Methadone has the reputation of not producing respiratory depression in therapeutic doses, but in higher than therapeutic doses it will produce respiratory depression by a way of depressing the centers of the respiratory centers of the brain,

THE COURT: What is higher than a therapeutic dose?

THE WITNESS: A therapeutic dose is generally considered to be about ten milligrams. Twenty milligrams would be considered to be the beginning of a high dose.

Q Have you had occasion, doctor, to study or evaluate methadone maintenance treatment programs?

A Yes, I have.

Q In what connection was that? In what capacity did you perform these studies or evaluations?

A I believe my credentials show that I was a consultant to the Joint Legislative Committee, the Sub-Committee on Drug Abuse and while I was a consultant in this capacity I was asked to look at and survey the various programs with a view towards State funding and things of that nature. I have also had the opportunity to look at programs here in the City and outside of the City by reason of my investigations.

THE COURT: When were you a consultant to the Legislative Committee?

THE WITNESS: The date was about three years go.

THE COURT: Over what period of time?

THE WITNESS: For a year.

THE COURT: So that would have been 1971?

THE WITNESS: About 1970, 1971, yes. I would have to look up the exact calendar dates.

THE COURT: And you observed the methadone program since 1971; is that it?

THE WITNESS: Yes. Yes, I visited one program, as a matter of fact, as late as last Friday.

THE COURT: Go ahead.

Q Did you in the course of your studies and evaluations of the methadone program, the visits to the methadone programs, did you form an opinion with respect to the programs?

A May I ask in what regard?

Q First as to the efficacy of the programs.

A Well, first of all, it has been my experience the programs are effective in some fashion in helping to treat or to maintain heroin addicts on methadone. From what I could see, there is a great dropout rate and I have my doubts as to the efficacy of methadone per se as a treatment modality.

Q Does the narcotic addict, doctor, have an additional burden that other people don't bear so far as his physical health, mental health, his ability to perform tasks?

A I would say yes. While a methadone addict is under treatment with methadone he is taking a drug which is classified as a central nervous system depressant. In my experience it is a central nervous system depressant. I would say that regardless of the fact that the person has been on methadone for any period of time, he still will display some degree of inhibition of these central functions. Perhaps it may be within a short period after he takes the drug. Your Honor asked about a dose before and the idea of a dose is merely that it is a concept. It is an amount of a drug that must reach a particular site of action in order to achieve and effect a concentration at that particular point.

What I would rather consider, rather than a dose, would be a blood level of a substance after it has been ingested or taken into the body and has gotten in the circulation.

From evidence to date, it appears that methadone is absorbed rather rapidly, within, probably thirty minutes to one hour. After absorption it reaches peak levels insofar as blood concentrations are concerned and then the blood level slowly diminishes. It has the advantage over morphine, for example, as an analgesic pain killer that is longer lasting. A single dose may remain in the body as long as 24 hours if the dose is high enough.

THE COURT: And it reaches its maximum concentration in the blood, say, within thirty minutes?

THE WITNESS: Thirty minutes to one hour.

THE COURT: Maximum concentration was the term you used; is that right?

THE WITNESS: Maximum blood level is achieved.

THE COURT: Meaning the maximum amount of methadone in the blood?

THE WITNESS: That will be in the blood at any one time, concentration.

THE COURT: Then it gradually reduces?

THE WITNESS: Yes.

Now, the point that I am trying to make is that it will reach a peak and then it gradually diminishes in concentration. The peak activity would be, of course, correspondent with that period of thirty minutes to one hour, then gradually diminishing. At the end of 24 hours not all of the drug has been eliminated from the body, so, if you administer another dose the drug will achieve again the same level of concentration plus a quantity.

Now, this is not merely speculation. Methadone either, as they say, de novo in a naive individual is capable of producing addiction in the classical sense of drug dependency as they describe it. It is also capable of substituting for morphine or heroin. There is no question about that. That is why it is used in maintenance programs, but the substitution is not merely one of maintenance, if I'm phrasing it correctly. But, as a matter of fact, and this is again from experience, my own experience and others' experience, if you take a person who is on methadone maintenance and abruptly withdraw the drug completely from that person, the person will display the abstinence syndrome, withdrawl symptoms.

Now, this goes back to what I said previously about the concentration in the blood of the individual who is on methadone maintenance. If at the end of 24 hours he were totally free of methadone, I anticipate that he is going to start to display symptoms of the abstinent syndrome. The fact of the matter is that he doesn't, at least in a way that we can measure.

THE COURT: Is there some problem about the increased level? You said that the next day's dose is added to the little residue of the previous day's dose. Is that something that the clinics know about? Don't they reduce the dosage?

THE WITNESS: No. Your Honor, it is really not necessary at this point to reduce the dose because the person is using this as additional residue to satisfy his tolerance needs.

THE COURT: Is there a problem about that from any standpoint?

THE WITNESS: Yes, because it could increase the central inhibition. It does not seem to, apparently it does not, because the person is developing as he goes along in 24 hours, he is developing further tolerance. Tolerance to the sedative effect is what I'm referring to. The sedative effect -- at the end of 24 hours there will be no sedative effect to speak of.

THE COURT: So he is getting more of methadone but he is developing more of a tolerance?

THE WITNESS: Yes.

THE COURT: What do I conclude from that?

THE WITNESS: Well, this is one of the explanations that is given for the ability to administer methadone at a rather static dose for the period of time.

In other words, your Honor, methadone belongs to a class a pharmacological class of compounds that will generate tolerance in an individual. Tolerance means specifically that more and more of the drug has to be taken into the system to satisfy biological needs.

In this instance the drug is not being displaced from the binding site at a very rapid rate. It is remaining within the system. You are adding in subsequent doses. You are attempting to or you are overcoming a part of the tolerance that is developing so that the person appears to be satisfied, but I would judge that at a point in time -- I'm not -- I can't state this more than empirically: That at a point in time a person's tolerance would break out and he will display the need for more of the drug or other drugs of a similar nature.

THE COURT: I just haven't followed you completely. What is it that you say leads to his tolerance breaking out or breaking down?

THE WITNESS: The inability of the standard dose to satisfy that.

THE COURT: I see. In other words, the tolerance may go faster than the dose?

THE WITNESS: Than the dose is able to satisfy.

THE COURT: If the tolerance builds up, what is it that is breaking down?

THE WITNESS: His basic need for a drug. A person takes heroin or takes any drug for a reason and this is whatever the motivation is, whatever the urge is that causes him to take this drug is satisfied by the drug. When the drug is no longer able to satisfy this motivation, he has displayed a tolerance to the effect of the drug, so it is really this basic urge or motivation that is coming to the forefront when he is no longer able to satisfy the need with the standard dose.

THE COURT: I can see the theory. What observation have you got on this?

THE WITNESS: I would say that one of the reasons why a proportion of methadone maintenance patients go to other drugs and specifically to alcohol -- this is evidence of what I'm trying to point out.

THE COURT: Are there facts that you have that help you come to this conclusion about the frequency with which this occurs?

Maybe you were going to do that, Mr. Dunn.

MR. DUNN: I was hoping to, your Honor.

THE COURT: You go ahead.

Q Doctor, are you aware of the side effects experienced by persons taking methadone?

A Yes.

Q Can you describe these side effects?

A They vary, depending upon the duration which a person has been taking the drug. Primarily, it is what I would describe as sedation. The drug taker himself might describe it as lethargy. Last week one patient indicated to me that he felt sluggish and I would assume that in a person who is new into a program that this would be quite obvious, the sedation, the depressant action.

A person becomes relatively rapidly tolerant to the effects insofar as the intestinal activity is concerned, the, you know, lack of bowel activity.

THE COURT: Let's take the sedation. Don't they develop a tolerance on that score?

THE WITNESS: They do after a period of time. I'm talking about the person who is in the program initially.

THE COURT: But how long does it take to develop a tolerance to the sedation effect?

THE WITNESS: Even with therapeutic doses they indicate that tolerance to the sedative effect with methadone is in the range of about six months.

THE COURT: We are talking about more than therapeutic doses. We are talking about --

THE WITNESS: Yes, we are. What I am trying to say actually is that tolerance in methadone, to the sedative effect with methadone maintenance would probably be a longer occurrence.

THE COURT: Like what, a year, two years?

THE WITNESS: I would say perhaps a year.

THE COURT: During that year, let's say after six months -- let's give the fellow time to get on the program -- how much of a problem is he going to have about the drowsiness or sluggishness?

THE WITNESS: I would judge he is going to have a problem within a short period of time after he takes his drug and if we are talking about a person who is on methadone maintenance therapy, 100 to 120 milligrams for a day, I would say that periodically during every day when he takes his medication there is going to be a time when this is going to have some effect on his activities, particularly I would say, in his ability to make certain types of judgments.

For example, in operating a motor vehicle, thinking about driving a car, you have to make a judgment that will, you know, prevent an accident or something like this. I would say that there would be some degree of inhibition of this judgment.

THE COURT: If a fellow takes his dose at eight in the morning, how long is it going to be a problem to him?

THE WITNESS: I would judge until three or four o'clock in the afternoon.

THE COURT: That long?

THE WITNESS: Yes, sir.

THE COURT: Of course, I guess this all varies depending on how much tolerance he has built up.

THE WITNESS: Yes. There is something else, too, your Honor, that I think enters into the picture. When you are dealing with a report of the statistical analysis of a program, a whole program, say a thousand cases, you are dealing with a group of individuals who have each contributed to those results and what I think that we have to be aware of is that in individuals there is going to be a wide variation of response.

Some people are going to prove to be an exception to the rule and they are not going to have a very severe response to the drug after a year or two years on methadone maintenance.

On the other hand, you have the person who is going to respond very adversely. So that the two together incorporated into an overall picture, a mean result, is going to be contributions of both individuals.

I know that there will be people -- I have talked to them in programs -- who appear to be perfectly normal, lucid, coherent and they will be normal or appear to be normal. But, on the other hand, there are many other individuals who are still depressed after a year.

Now, Dr. Dole and Dr. Nyswander both will admit --

THE COURT: Dr. Dole is the Rockefeller Institute doctor?

THE WITNESS: Yes.

THE COURT: And Dr. Nyswander?

THE WITNESS: His colleague, his wife.

THE COURT: Colleague and what?

THE WITNESS: The methadone program that they initiated back in 1965 - 1966. They both admit that, for example, when they selected the patients into their methadone maintenance programs they were selected. They eliminated what they call the psychopathological personality, and this was the individual whom they felt they would have very poor success with, the person who had a peculiar type of motivational syndrome that might have been biochemical in origin.

THE COURT: The thing is that can't you detect, if you are an employer, can't you make the same kind of a judgment that Dr. Dole and Dr. Nyswander made? You selected the people that you think have freedom from the difficulties. You select the people who don't have the drowsiness problem. Can't you judge who is going to be of what characteristic and who isn't?

THE WITNESS: Even insofar as Dr. Dole and Dr. Nyswander's initial efforts are concerned, and I believe it holds true even today, you can select an individual who may appear to be a potential candidate for success, but there is no way of predicting success for that individual.

There may be a statistic that comes out and says: "Okay, 85% or 87% of the people who are in this program for a period of this many months appear to be productive," but again you are dealing with a gross statistic. You are not dealing with individuals.

I will say, yes, there are probably exceptions to the case where a person can be put on methadone maintenance and appear to perform normally after a specified period of time, provided the program is carried out properly with not only methadone maintenance but also psychological counseling, which is, by the way, and seems to be almost of a continuous nature.

I said that Dr. Dole and Dr. Nyswander attempted to discard the psychopathological personality, but again this is really not possible because the term psychopathological personality can be described but it can't be measured. This is the point.

THE COURT: Didn't they succeed in weeding those people out? Did they have people who they thought were okay come into their experiments and then found out they weren't okay?

THE WITNESS: That is right.

THE COURT: The latter is the case?

THE WITNESS: The latter is the case.

THE COURT: What happened to the people who didn't work out? They dropped out of the program or reverted to heroin or what?

THE WITNESS: There was a study and there have been several studies that have been reported by Dr. Dole and Dr. Nyswander and their colleagues indicating, for example, I recall one study that indicated that there were approximately 750 patients who, say, entered a program in 1968 and one year later or two years later a certain proportion of those people were still in the program and apparently productive.

Let's say that the statistic was around 80 to 85% that was still in the program and still productive. They indicate that some of those people discharged themselves voluntarily. They indicated that in a couple of cases the people -- I think there was 1% death within the program for various reasons. Some of the patients were discharged from the program because of other reasons. The other reasons were that in the initial studies all of the patients were prison inmates and some of the prisoners, when their term came to an end, left the program. They became, as it were, ambulatory and they never came back.

During the period of time that the pilot study was underway they were still admitting patients into the program, so in the beginning you got 750 patients as the initial complement of patients and in the end you got 80% of those 750 or 80% of that number remaining in the program, but they may not have been the same patients, and it is indicated that some of them were absorbed.

THE COURT: Is this the Dole - Nyswander program or what program?

THE WITNESS: Yes, it is.

THE COURT: And you are saying that they have based their percentages -- we don't have evidence in now about that program so we can't --

MR. DUNN: There will be, your Honor, if I may just interject a moment. I understand the plaintiffs are going before Dr. Gearing this afternoon to submit a statistical evaluation presented by Dr. Gearing or prepared by Dr. Gearing and in that sense I believe Dr. Lynch would be of some assistance in assisting the Court in viewing the objectivity of the report of Dr. Gearing. I have Dr. Gearing's report. We could mark it for identification now, if your Honor permits, and then I can ask Dr. Lynch's opinion of this.

THE COURT: Yes. I think we had better take our luncheon recess until 2:15 this afternoon.

[Defendants' Exhibit J marked for identification.]

[Trial recessed until 2:15 p.m.]

AFTERNOON SESSION

[2:25 p.m.]

THE COURT: As I understand it, Mrs. Gold, you have a substitute and you need to leave right now.

MRS. GOLD: Yes.

THE COURT: That is okay.

MRS. GOLD: Thank you very much.

THE COURT: I had suggested having a look, a view of the Transit Authority facilities which I'm very much interested in, but my Clerk just said that there was some response to that.

MR. SUMMERS: He spoke to me about it. I said if the judge is really serious about it we can certainly set it up if we know when it is convenient.

THE COURT: Does anybody object?

MISS DU BOIS: We wouldn't object, your Honor, but we would want to make sure that it included the offices, the garages, the yards and that it be in the daytime so that we could get a typical sampling, not a selective version.

THE COURT: That is fine with me.

MR. DUNN: If I can suggest this: Would the Court express its desires with respect to particularly what it wanted to see on the system? If so, we then would arrange a tour to include those things specifically that the Court feels it wants to see.

THE COURT: For instance, there has been a description of work at a yard. I think I can get a lot more idea if I looked at a yard, and the setup in a station. I'm in subway station all the time, but, I mean physically seeing what a tower is and analyzing the operation of a train, and seeing how it operates, and these things, which may seem kind of silly because, you know, I think we see it every day, but really I don't in the sense that I'm interested in seeing it now. So, I am interested in seeing the yard, what has been referred to as a tower or the control tower, seeing the operation of a station, who actually is there doing what.

Miss DuBois has a very good point. We are going to do that also, take in the offices. I suppose the office work is a little more akin to something within my experience and yet it would probably help to see if there is anything unique about these offices, so I just think that I would like to see the whole thing on a sample basis.

MISS DU BOIS: Can we have our transportation expert try to work something out with the Transit Authority as to the kind of things we would like to have included?

THE COURT: It seems to me what would be a good idea is to start in the middle of the afternoon when the normal working day is going on, the daytime situation, and then either go through until late at night or take a break and resume late at night so we see these night conditions that have been described.

MR. DUNN: Would it be of assistance, your Honor, if we submit a proposed itinerary to the Court with a copy to counsel and if counsel has other areas they feel the Court would be interested in, then the Court can decide.

THE COURT: Ideal.

MISS DU BOIS: Fine.

MR. DUNN: We will undertake that.

THE COURT: I think we can do it sometime -- I was thinking of tomorrow night, but I think that really does not work out very well. We can do it sometime next week. Let's head for next week.

MR. BALBER: One more minor thing: There is one of Plaintiffs' witnesses in the courtroom. I believe that her studies were going to be the subject matter of this witness' testimony and I request that she be permitted to listen.

THE COURT: Any objection?

MR. DUNN: None whatsoever, with the proviso that we reserve the right to recall Dr. Lynch after Dr. Gearing's testimony.

THE COURT: Of course.

MR. DUNN: I offer this for admission. Counsel for the plaintiffs have seen it and they provided a copy to us. This is Dr. Gearing's study.

THE COURT: You don't want to introduce that as a defendant's exhibit, do you? Why don't you call that a plaintiffs' exhibit and I will permit you to use it.

[Plaintiffs' Exhibit 45 received in evidence.]

VINCENT PAUL LYNCH, resumed.

DIRECT EXAMINATION [continued]

BY MR. DUNN:

THE COURT: Can we set the tour down for a week from tomorrow tentatively? We will see how that works out.

MR. DUNN: Yes. That would be starting sometime in the afternoon?

THE COURT: Why don't we just see how much we can cover and I would think, just offhand, that we would start during the working day, have a portion of the tour during the regular working day, and a portion of the tour at night. That would be most helpful to me.

MR. DUNN: Surely.

Q Dr. Lynch, before we broke for lunch you were discussing the tolerance that develops through a narcotic and you were discussing specifically the tolerance as it develops in a person participating in a methadone maintenance treatment program. Was it your statement that the person on the methadone maintenance treatment program develops increasing tolerance to methadone?

A I don't recall what my statement was, you know, exactly, but what I should have said, if anything, was that the person develops continuing tolerance; that the tolerance level does increase as the time goes on.

Q Does it follow, doctor, that the person then must take increasing doses of a narcotic to maintain the same level?

A I would say in a majority of cases, yes, that eventually, yes, this is going to have to happen.

Q We have been told that there is such a thing as stablizing a person on methadone; that a person may be gradually built up to a dosage of 80, 100 or 120 milligrams of methadone and remain stable at that dosage. Does such a person continue to develop a tolerance to the drug methadone?

A Yes, he does.

BY THE COURT:

Q Can I just go back on that. I don't understand the very first thing you said this afternoon. You are saying that a patient would have to have increasing doses of methadone to do something with respect to the tolerance. What is he doing with respect to the tolerance?

A The tolerance is increasing and he is satisfying the tolerance as it develops. Tolerance means an increasing need for the drug and its effects, so he builds up, as it were, an immunity to the drug's effects. That is a tolerance. I hate to use the word immunity because it is not of an allergic immunity type of response.

Q There is something that is worrying me. I don't know how to articulate it, but the picture I have is that the man on the methadone maintenance program -- let me go back. The picture I have is that the man who is the so-called heroin addict has to have that heroin regardless of whether he is seeking pleasure or he has a physical demand for that heroin and if he doesn't get it he has got these so-called withdrawal symptoms;

is that right?

A That is absolutely the case, yes.

Q And what is it that happens to the man who is the heroin addict; what are those things that cause the physical demand for heroin? What are those things?

A To be quite candid, your Honor, I don't know and I don't know that anyone really does know. We can speculate in this area.

Q Just tell me as much as you do know.

A The body seems to adopt itself to the presence of these chemical compounds, the foreign chemical compounds, and adopt them, as it were, until they become native substances that are required in certain cases of metabolism at a biochemical and cellular level.

Q The man who has had a shot of heroin and he is what we call an addict, and then he doesn't get his shot. What does he feel like?

A The drug in its course of action alters various biochemical mechanisms, upsets these mechanisms in its course of action. The mechanisms then re-adjust to the presence of the drug and they function in, perhaps, a comparatively new fashion with the drug, in a comparatively normal fashion.

Q You are putting it in a very medical way.

I am asking this question: If I were on heroin and I didn't get my shot and I was addicted, how would I feel; what would be happening?

A You'd feel very uncomfortable.

Q In what way?

A You begin, for example, by feeling an itchiness around the nose and the mouth. There is a drying sensation that you begin to feel. You feel then an increase in secretions and you will see an addict person --

Q A runny nose?

A A runny nose, the watery eyes, and then you begin to feel anxious and anxiety, you know, "Am I going to get my shot? Am I going to go into convulsions?"

I have heard all sorts of horrible things.

Q If I don't get it, am I going to get convulsions?

A No, not necessarily. At least it is not a physiological event that occurs. Much of the withdrawal, say, 40% of withdrawal, is psychologically produced. A person -- it is quite evident that you are thinking about a person who is undergoing withdrawal, a person who has been medically put into this situation, a medical addict. A medical addict does not have the same degree of severe responsibility that a person who is a voluntary addict does.

Q You mean a medical addict being somebody to whom drugs had been prescribed?

A Have been prescribed.

Q Now, as to the voluntary addict you are saying that a lot of the problem is the dread of this event?

A The psychological component in addiction is a major effect. In my estimation it is the major component of addiction.

Q Can you describe any more definitely psychological component?

A Yes, if you have ever gotten together with a group of drug takers, drug abusers and sat down and discussed the drugs with them, they have a lot of ideas, many of which are misconceptions, many errors that come into their way of life, beliefs they have developed or that they have obtained from others. Some of this comes from the news media. Some of it comes from watching television, et cetera. A junky going into -- a heroin addict going into withdrawal portrayed as riding on the floor and in intensive pain. You say convulsions, vomitting, nausea. This is what I mean by the psychological induction of things that severe.

Q I thought those things happened physciologically and you are saying that they don't necessarily happen but only are dreaded; is that right?

A They do happen because of the dread. The mind can produce these phenomena, not necessarily the absence of the drug.

Q You are saying from just a chemical standpoint there is no necessary reason for a convulsion?

A No. This is what I'm saying. That is exactly what I'm saying.

Q Or for vomiting?

A Or for vomiting. Vomiting, I'll withdraw that. Vomiting and possibly diarhrea would be autonomic functions, as I indicated.

Q It could happen physically?

A Yes.

Q What are the things that are dreaded that are really the result of dread?

A Convulsions, intense muscle cramping, the fear that these things are going to happen.

Q What other things besides convulsions and muscle cramps?

A Some people have told me that if they allow themselves to go cold turkey, to withdraw abruptly, that it is liable to kill them. They have heard about this death.

Q Is there any hallucinations or anything?

A There appear in some instances hallucinations.

Q Is this a psychological problem?

A No, I would say this is primarily chemical.

Q So you have got a group of chemical things and you have got a group of psychological problems?

A Yes.

Q And I guess there would be always the psychological problem of dread of any of these things happening; right?

A Yes. This is one of the good features of a medically supervised, correctly supervised program where the patient has medical aid and counseling, but, for example,if a person who is on methadone maintenance certainly decides: "This is not the way I want to continue my life. I would like to be drug-free so I'll go into detoxification."

I know of methadone maintenance programs that will take their patients into detoxification voluntarily and they begin to decrease the dose of the drug that is being given. A patient gets down to about ten milligrams. That seems to be a kind of a breaking point. The patient is of approximately a week away from complete detoxification and at that point you see the development of a great deal of anxiety and fear and apprehension and in some cases a severe depression because he knows next week he is not going to have a crutch; that he has had the chemical that he has had for a long period of time to allay, you know, to the onuses that he might have had to -- all right.

Q Let me get back. I had a lot of inquiry that I felt I wanted to ask about.

You described the withdrawal symptoms of heroin. Now, this doesn't take into account the desire for pleasure. There apparently is the need created by withdrawal symptoms that has nothing to do with what we might --

A Your Honor, the Expert Committee of the World Health Organization in 1965, when they first proposed the definition of drug dependence specified that insofar as drug dependence of the morphine type was concerned that there is an inordinate desire on the part of the addict to obtain the drug by any means in order to avoid the unpleasant nature of the drug. I'm not talking about the pleasure seeking but to avoid.

When we say drug dependence of morphine type, it is accepted that this also includes every other narcotic compound of an analogous nature. In other words, methadone is included here.

Q Now, the man who is the heroin addict and he has had his shot, he has to have more than one shot a day, doesn't he?

A Depending upon the strength of his habit, yes.

Q Anyway, does there come a time when the effect of one shot is beginning to expire and he knows that it is time to take the next shot?

A Yes.

Q And he begins to feel the first phases of the withdrawal symptoms; right?

A Yes.

Q Or he knows he [illegible]ll; right?

A Yes.

Q I guess maybe you can't generalize, but he is going to want to take your shot of heroin in order to prevent the withdrawal symptoms; right?

A Yes.

Q Is it also true that by taking that shot he will get some pleasurable effect in addition to just avoiding the agonies of withdrawal?

A I certainly assume that is true.

Q Is there an appreciable effect from heroin?

A A continuous pleasurable effect?

Q After he takes his shot, is there any?

A I believe so far as the heroin addict is concerned, yes.

Q In other words, this is the so-called high people you talk about?

A Yes, euphoria.

Q Is this something that people that have a craving for, that the heroin addict has a craving for?

A Yes.

Q Now, if one could analyze the thinking of the heroin addict you would say that he probably has the idea that he is going to avoid the pain of withdrawal and probably get some euphoria?

A Yes.

Q Now that brings me back to the question of the tolerance developed in methadone. If a methadone user has developed a tolerance, what does that mean?

A It means that he has reached a point in his taking the drug where the drug no longer is able to satisfy his requirements.

Q I now remember what I was puzzled in my mind

Does it mean that this dosage is insufficient to prevent the withdrawal symptoms; is that what you mean by tolerance?

A Yes, that is what it means, yes, sufficient to prevent that.

Q What other withdrawal symptoms are there from methadone?

A One of the advantages for methadone that was discovered when it was introduced initially is that methadone produces approximately the same qualitative type of withdrawal symptoms. In other words, a person does feel happy, hence if he does have the itchy,running nose, nausea and vomiting and possibly muscle pains, cramps to a much lesser degree.

Q Than heroin?

A Than heroin, yes. The literature tells you that the withdrawal period is much less stormy than with heroin and that in the beginning, when methadone was used as a treatment for heroin addiction, it was used precisely in that way. You would take a heroin addict and completely satisfy his heroin requirements with methadone and then proceed with a gradual withdrawal with methadone ultimately when he reached the break-through point, zero percent of drugs, he may show mild withdrawal symptoms, symptoms that will not really incapacitate him or be unpleasant.

Q Let's go back a step. When the heroin addict comes into the methadone clinic he is given a dosage of methadone.

A May say something?

Q Yes.

A We have to establish specifically whether it is a methadone detoxification clinic or a methadone maintenance clinic.

Q Let's take the methadone maintenance clinic patient. He comes to the methadone maintenance clinic and one of the things that they give him quick is a dosage of methadone; right?

A Yes.

Q Can he be given the dosage of methadone which is sufficient to prevent him from having the heroin withdrawal symptoms?

A Yes.

Q What I'm finally getting around to is the distinction between the withdrawal symptoms and the pleasurable factors. What does the methadone do as far as the pleasurable effect or the craving for the pleasurable effect or the desire for it, whatever occurs. The fellow comes into the methadone clinic. He is about to have withdrawal symptoms from heroin which he dreads intensely and you are saying that you can give him a dosage of methadone sufficient to prevent that; right?

A Yes.

Q I don't understand what that does to any desire he may have for the high, for the kick.

A If I might answer you this way: It is my impression that it doesn't do very much. The methadone in this situation is acting presumably at exactly the same site in the brain that the heroin acted in altering the biochemical activities. That is how the withdrawal symptoms are alleviated. But the basic, underlying reason why the person took heroin to begin with is not alleviated by this particular procedure.

Q In other words, if a man were for some reason to have a desire for heroin, for its euphoric effect, that is not going to be satisfied by methadone. Does he get a euphoric effect from the methadone?

Let's take that first instance where he has come into the clinic. Is he going to get any euphoric effect from the methadone?

A I'm not trying to equivocate but in some cases and in some cases no. In cases where he gets a degree of euphoric effect, he will probably continue with the program. When he finds that he does -- that all of his needs are not satisfied, he is liable to be the one who is going to drop out of the program.

Q In other words, depending on the individual, he may get some euphoric effect or he may not get much; is that right?

A That is right.

Q Is the methadone as strong in giving the euphoric effect as the heroin was ?

A No, not by the oral route.

Q By the way, what they do in the methadone clinic for the patient, he is not going to get as much euphoric effect as from heroin; right?

A No, right, correct.

Q Now, we can go on. He develops a tolerance, as you would describe it, to the methadone as he goes along?

A Yes.

Q You are saying that the tolerance is a situation where it isn't even enough to prevent the withdrawal symptoms; right?

A I would say over a period of time, yes, within a certain period of time, a year or possibly two years. There has got to be some alteration in the dosage of methadone in order to maintain the status quo with regard to preventing withdrawal symptoms. In addition, many -- this is a matter of record again --

Q Which means increasing?

A Increasing, yes. In other words, your Honor, where a methadone program says they will maintain the patient at 100 to 120 milligrams per day, I do not agree that this concept in the long run cannot be.

Chronocologically this is an impossibility. But the drug has to be increased in order to overcome the tolerance that is developing.

Q That is your theory.

A Your Honor --

Q What about in practice?

A Our limitation insofar as the experimentation is concerned is based upon a number of considerations one of which is kind of ethical, so consequently we have not established any models, established any human models for studies of this nature. We have established animal models and we found that the -- our animal subjects demonstrate the conditions analogous to withdrawal when we try to maintain on a static dosage over a period of time, so we have to increase the dosage in order to alleviate.

Q There are human beings that have been given standard dosages for many months or years, have there not?

A Yes.

Q What happens with those people?

A Apparently these are the people who are developing other drug problems. The current concept appears -- the current idea appears to be that many of these people are turning to alcohol. They are becoming alcoholics. Alcohol is a substitute or reinforcement or potentiating agent so far as methadone is concerned.

Q In order to prevent withdrawal symptoms?

A Possibly to prevent withdrawal symptoms and possibly to give them a degree of euphoria that methadone has not given them.

Q When we are talking about an attempt to prevent withdrawal symptoms, we are not talking about the attempt to give euphoria, right?

A That is right.

Q Now, the people who -- I guess this probably follows from the earlier answer that you gave -- on these methadone programs continue and the people get stabilized to the extent that they can be stabilized. Do you know whether they are receiving any euphoria from the methadone?

A The patients that I have talked to recently have said no.

THE COURT: Now, does the methadone,as it is used over a long period of time, months, or into say, one or two years, does it show cure, the desire for the euphoria?

THE WITNESS: Not to my knowledge.

THE COURT: Okay, I have gone as far as I can.

BY MR. DUNN:

Q The methadone patient, Dr. Lynch, that is stabilized on a high methadone dosage, between 80 and 120 milligrams, for example, to satisfy the tolerance that develops, does he have an alternative to increasing the dosage, and would that alternative be to potentiate the effect of methadone by using another drug?

A That's the probable case. All during the course of investigations that have been made with people who are described as heroin addicts, it's been noted that in this instance, if a heroin addict reaches a point where he cannot obtain a fix,he will certainly and freely turn to something else to satisy his needs and allay the withdrawal symptoms.

Alcohol is probably the commonest, with barbituates and/or any other central nervous system depressant.

I have spoken with patients who tell me that they have even tried amphetamines and drugs like LSD and a variety of other hallucenogenic agents in order to avoid withdrawal. But the central simulants and the hallucenogenic drugs are not as positive in their action as are the drugs which would be central nervous system depressants, particularly alcohol.

I would assume in the case of methadone, since we are talking about an analogous drug it would be precisely the same thing. I would visualize the methadone maintenance person who wants to increase his dosage on his own doing so with alcohol or with some of the readily obtainable tranquilizers like librium, valium and the like.

Q Does methadone in any way block the effects of amphetamine, barbituates, codeine or alcohol?

A Can I hear the question again?

Q Does methadone, in any way, block the effects of amphetamines, barbituates, codeine and alcohol?

A I would have to take those on an individual basis.

Q Would you please, Doctor?

A Methadone would be a physiological antagonist of amphetamines, it would potentiate codeine, barbituates, and alcohol, acting in the same way.

Q What percentage, Doctor, of narcotic addiction, if you know are iatrogenic or medically induced addicts?

A The precise figure is simply impossible to give, but I would say relatively small.

Q Could you venture an opinion with respect to percentages or rough approximation?

A Five percent.

Q Would the prognosis for this five percent be different than the prognosis for the 95 percent of narcotics addicts that were not medically induced?

A Definitely.

Q What would the difference be, Doctor?

A The prognosis for the iatrogenic, medically-induced addiction is very good. I would say out of the 5 percent you probably get two and half, three percent, the cure rate, you would get a rate or recidivism for relapse, but you would get another higher percentage of drug-free individuals, than you would with the voluntary addict.

Now, that's not to say that among the voluntary addicts you would not find some ultimately some drug-free individuals.

Q Do you have an opinion, Doctor, as to the percentage of persons whose prognosis would be good in this 95 percent of self-induced addicts?

A I'd rather not answer that question.

Q Can you define two terms that we have been using, I guess interchangeably, but the term "addicted," the term "dependency," and can you, if there is any difference between the two of them, distinguish the two terms for us.

A Up until 1965, the term "addiction" was the generally acceptable term describing a classical syndrome, which would includ --oh, a syndrome which would have four characteristics, let's put it that way.

A person would repeatedly take a drug and as a matter of fact, establish the habit of taking a drug for this what we now call a psychological dependency on that drug.

During the course of taking the drug repeatedly at the same dose, he begins to develop tolerance. He will increase the dose in order to satisfy his initial psychological needs, so the first characteristic is the psychological dependency, the second characteristic would be the development of tolerance.

In the process of taking the drug into the system, very elaborately apparently by, oh, chemical changes begin to take place.

For example, one of the first things, and we know this exists, one of the first things that is involved here is an alteration in the system of enzymens within the liver. This particular enzyme system has as its role the metabolism of a variety of different drugs.

Now, these enzyme levels raise in response to the presence of the drug. They are not necessarily there before the drug. They may be induced by the presence of the drug.

This is a concept that we call enzyme induction.

There are other bio-chemical alterations that take place. In the brain, it would probably be again in the area of cerebral cortex, possibly in the area of the mid-brain, I would visualize hypothalmic regions becoming involved and also the medulla response of the brain, involving both the central nervous system and the autonomic nervous system, and probably, again, enzymes as a basis or bio-chemical functions with the cell as a basis for change.

At the present time, we have not been able to measure or to illustrate precisely were these changes occur but we know that they occur because when we take the drug away abruptly from an individual, the development is the abstinent syndrome.

What I am trying to indicate here is the third characteristic is really the development of a physiological, biochemical form of dependence, and then the fourth characteristic for this classical syndrome of addiction would be development of withdrawal.

Now, in 1965, World Health Organization appointed an expert committee to try to reduce some of the inconsistencies that exist in this particular area.

At that time, prior to 1960, if I were to say that an amphetamine produced addiction, I would be laughed out of court, because it does not produce addiction in the classical sense.

Q What does it produce, Doctor?

A It doesn't, for example, produce much by way of withdrawal symptoms, so that we can't say that there wasa physiological dependence. It produces certainly psychological dependence and tolerance, but not the other characteristics of the classical definition.

Therefore, the reason why the expert committee was appointed to reduce these inconsistencies. When they came up with their final report, which is now accepted worldwide, they came up with a definition of a concept of drug dependence.

They did not define the condition, but they defined the concept. And they said that drug dependence was produced by the repeated taking of any chemical substance. The nature of the drug dependence was determined by the drug and what it produced during the course of the ingestion.

Now, what does that mean?

Well, it means that then we can describe drug dependence of the opiate type, taking in all ofthe compounds related to morphine, the semi-synthetic compounds like methadone. The description of the condition is based upon what happens to the individual during the course of dependence and what symptoms he demonstrates by way of withdrawal.

And it satisfies the question about amphetamines, amphetamines produce -- there is a dependence of the amphetamine type, psychological dependence, tolerance, not necessarily withdrawal. It is a concept.

Q Can one become addicted to peanuts?

A Yes. There is a famous German toxicologist by the name of Lewin. He published his last book in 1930, but he studied the area of drug dependence as we call it now very, very thoroughly over a period of 30 to 40 years, and he illustrates in his writings cases of individuals becoming dependent or addicted on a variety of substances that we would term completely harmless and innocuous:

Water, for example, certainly I am not implying a physical or physiological dependence, but what I am trying to point out is the psychological aspects of dependence. In my estimation, that is the most important part of the whole problem.

Q Surely, peanuts addiction would not be treated with methadone?

A No.

Q Is there a distinction between the type of addiction that occurs when one addicts onself to heroin or one addicts oneself to, say, scrambled eggs?

A I don't understand the question.

THE COURT: Sorry, I mentioned scrambled egg.

MR. DUNN: Shall I withdraw the question, your Honor?

THE COURT: Let's. We have enough problems without that.

MR. DUNN: Please withdraw the question.

Q Is there a difference between the addiction that takes place when one addicts oneself to heroin and when one addicts oneself to some innocuous food?

A If I understand the questioncorrectly, I would say yes, the difference being in the non-development of , oh, the physical dependence, the non-development of what really would be described as withdrawal symptoms of a physical nature.

Q Is there a difference, pharmachologically and physiologically between the effect of methadone on the human body and the effect of insulin on the human body? Can you distinguish between the effects of the two drugs?

A They are two completely different substances, biochemically and physiologically and pharmachologically.

Methadone is not a native substance. Insulin is a native substance required by the body to carry out what we would describe as rather basic phsiological or biological functions.

Q What do you mean by native?

A Manufactured by cells in the body for use in metabolic processes, necessary. If you don't have insulin, you develop diabetes mellitus, sugar diabetes.

I don't understand the comparison that's made between the two.

Q Is there any basis for comparing the two as being analogous, having analogous effects on the human body?

A No. They certainly don't act the same way, they don't act -- they don't act at the same site.

One, in the case of insulin, we are talking about the treatment, the use of insulin in the treatment of a diabetic or the use of insulin in the production of convulsions in insulin shock therapy.

In methadone we are talking about its use in the alleviation of pain as an analgesic, or we are talking about its -- methadone is used in detoxification programs for heroin addiction or methadone is used in maintenance programs -- we are talking about a therapeutic use for methadone, but that's about the analogy between the two that I could see would be the therapeutic use of each one.

Q What effect, if any, does insulin have on the brain, is that a site of operation or site of --

A Well, as it is understood, insulin facilitates the uptake of glucose by its cells and also the metabolism of glucose for the development of energy.

I would assume that if insulin were used by brain cells it would be used in this way as it is used in every other body cell or tissue.

Q It would not alter the brain cells in any way?

A Not under ordinary circumstances.

Q Would methadone?

A May I make a --

Q Yes, or course.

A -- an explanation of that.

Insulain, when it is used under ordinary circumstances, I mean insulin when it is used in the treatment of diabetes mellitus. I don't mean when it is used in the development of convulstions in shock therapy. There I might see harmful effects from insulin.

Q Does methadone act on the brain biology in a way different than insulin does?

A Oh, definitely.

Q How does the effect of methadone differ from the effect of insulin on the brain biology?

A I'm afraid I don't know. The mechanism, if that's what you're asking for? I don't know.

Q Is this an area that to your knowledge has been explored and conclusions reached in -- conclusions have been reached by the medical profession as to the actual effect of methadone on the various areas of the brain and components of the brain?

A There is no doubt that there are projects going on along these lines, but no conclusions have been drawn. If there were such conclusions I would have to admit that some of my own research would have to be thrown out because I am currently involved in a project of that nature.

Q Is the same true of insulin or is there a degree of medical certainty as to how insulin works?

A I would say a lot of the mechanisms of action of insulin are already known. Points of where it acts within the cell, the specific enzyme systems, yes.

Q Does methadone effect the hyperthalmus?

A To a degree, yes.

Q And what effect does it have on that organ and what results from the effect on the hyperthalmus?

A The hyperthalmus is involved in a great extent in the functioning of the autonomic nervous system. I say part of the effect that methadone has on the autonomic nervous system is immediated in that way. But there are some other things that come about. Some of the effects that methadone seems to have in some instances are almost hormonal in nature.

Heroin in the same way. Insofar as limiting the sex drive and diminishing sexual activity is concerned. What you would call the libido, diminished libido.

Q Does this diminished libido have the effect on the emotional stability of a person?

A I presume that there is a considerable interaction between the two, but as you mention it, the hyperthalmus is also a part of the brain functioning so far as modulating emotions is concerned.

Q Does it not have an effect on reaction?

A Emotional reaction?

Q Physical reaction.

A Yes, but then a person will become somewhat tolerant to that.

Q The effect on the hyperthalmus, is that stronger at some time during the course of treatment in the methadone maintenance treatment program, is it stronger at some point or points in time than it is at other points in time; that is, a person enters the methadone maintenance treatment program, and as I understand it, Doctor, the person is gradually built up in dosage and then reaches a plateau, at least with the administration of methadone, and at some point in time, may or may not start towards detoxification with decreasing doses.

Now, have you gone that process, can you point out any point or points in that process where the effect on the hyperthalmus would be greater or less than at other points, if you can?

A Insofar as this effect on libido is concerned, I would say that when the person reaches his plateau of dosage, this is when you are going to see the greatest inhibition of the venous functions and possibly after that, the person will begin to return to normal. At least this is according to testimony of individuals involved in the program, or involved in programs that I have been acquainted with.

Now, so far as emotions are concerned, I would say that in the beginning the emotional aspect is suppressed, and then as the program or the medication is continued, that this is where you begin to see the reactions on the part of the individual, emotional reactions, that the person, as it is described in the literature, when the individual becomes apprehensive and devisive and antagonistic within the program.

Q Does there come a point, Doctor, that the effect on the hyperthalmus becomes greater than at the point where the person reaches the plateau on which he is stabilized?

Is there a point in time after that that there may be a change in the effect?

THE COURT: I don't think we have to get into such fine points on the libido.

MR. DUNN: I may shorten it considerably, your Honor.

THE COURT: Okay. This is a court case and it is not -- we have got to get the proof in, but the main features we can look at, but not every last detail and every last symptom.

Q Does a patient, Doctor, react differently at different times in the methadone maintenance treatment program, different points in time of his treatment?

A Yes, I would say that after the person has been on methadone for a considerable length of time, he becomes more emotional and reactant, particularly put into a situation where he can't cope.

Q Would you say, Doctor, that every patient on the methadone maintenance treatment program is viewed at least potentially as a candidate for detoxification?

A I -- I hesitate to say that every person who goes into methadone maintenance could be detoxified.

Q That's not my question, Doctor. As a potential candidate for detoxification, possible the mirror image of the question would be, is it anticipated that eery patient on maintenance treatment programs, that every one of these people will remain in that program for the remainder of their

THE COURT: Oh, really, how can this -- this involves prophecy. This doesn't help me.

MR. DUNN: It involves it to this extent, your Honor, if I may.

As an employer we are asked to view methadone maintenance treatment program patients as being pretty much a homogenous group, and that --

THE COURT: I think it was just the opposite.

MR. DUNN: We are being asked to view persons who are satisfactorily participating in the program as one homogenous group.

THE COURT: Well, in a sense, maybe. Okay.

MR. DUNN: To this extent, your Honor, did I intend to pursue the questioning, and that is that a patient who is stablilized may or may not continue taking methadone in the program. He may reach a point in which either he elects or the program elects to detoxify him, and at that point, an additional risk is presentd. The risk is that the person is going to experience side effects that he had not experienced

MR. BALBER: I object to Mr. Dunn offering testimony.

THE COURT: No, no. Go ahead.

MR. DUNN: I am just making an offer of proof, your Honor, if the Court please.

THE COURT: Okay. And you say what? What can you say? Is the intention ultimately to detoxify them or is ti considered that they could safely stay on methadone for the rest of their lives? What's the objective?

THE WITNESS: Your Honor, it really depends upon the program and the person who is operating the program.

THE COURT: Okay, I was sure that would be the answer.

Let's go on.

Q Are you familiar with the policy, the federal policy, with respect to the methadone maintenance programs in the United States?

A In general, yes, sir.

Q Are you familiar with the Canadian federal policy with respect to methadone maintenance treatment program?

THE COURT: Can't somebody object? Why do we have to get into Canada?

MR. DUNN: To show that the United States, your Honor, with all due respect, is not the sole arbiter of the wisdom or lack of wisdom of using methadone maintenance.

MR. MORRILL: Your Honor, we can present evidence on England.

THE COURT: I know there are a lot of other countries in the world. We have had this witness on for a long time. Let's not get into Canada. I will not permit tesimony about Canada.

If Canada varies in its policy, it would not mean a thing to me. I've got to look at the T.A. policy on its merits and it is not conclusive what the Congress of the United States, its mainly the T.A. Certainly it is not Canada.

Please, let's not get into Canada.

Q Is there such a thing or have you heard the term, Doctor, of "heroin hunger"?

A Yes, sir, I have.

Q Can you tell me in what connection you have heard the term?

A This is a term that I have heard used by Dr. Benny Primm.

Q Who is Dr. Primm.

A Dr. Primm is director of the addiction services program of Brooklyn, I believe.

MISS DUBOIS: Does the witness want us to give us the name of the program?

THE COURT: What's the name of the program?

THE WITNESS: I believe it is the Addiction Services. The exact title I'm not sure.

MISS DUBOIS: It's the Addiction Research Treatment Corporation, your Honor.

THE COURT: And he is the director?

MISS DUBOIS: He was testifying about Dr. Primm, Benny Primm.

THE COURT: Is he with ARTC?

THE WITNESS: He is with that group, yes.

THE COURT: What's your question?

Q My question was directed to whether or not the witness is familiar with the term "heroin hunger." He said he was, and I asked him what connection he had heard the term and what it means, "heroin hunger."

A As I said, this was a term that I have seen used by Dr. Primm to describe the situation in which ultimately the patient is unable to overcome tolerance for probably the euphoric desires in taking methadone. And that he consequently must find some means of developing this euphoria. He's got to take -- well, Dr. Primm indicates that in many of the cases that he has seen --

MR. BALBER: Objection.

THE COURT: I think we better get Dr. Primm. He can't testify about what Dr. Primm found.

Q Were Dr. Primm's findings reported in the medical journal?

A One report that I have seen was in a 1973 issue from the Ontario, the journal of the Ontario Addiction

Research Foundation.

MR. DUNN: May we offer the -- Dr. Primm's findings?

THE COURT: Do you have it?

MR. BALBER: Your Honor, we will not accept that without an opportunity to cross examine Dr. Primm.

THE COURT: They object. Do you want to have it marked for identification so it is part of the record? I think we better take a break. Do you have any more cross for this witness?

MR. DUNN: Very limited, your Honor.

THE COURT: I meant any more direct.

MR. DUNN: Very limited.

THE COURT: Okay, we will take a very short break, about ten minutes.

(Recess taken.)

THE COURT: What do you want marked? I thought you were going to mark something during the recess.

MR. DUNN: Yes, your Honor, Defendants' Exhibit J.

[Defendants' Exhibit J marked for identification.]

MR. DUNN: That is the paper and the journal that the witness referred to, your Honor, which I offer.

THE COURT: This is an article by whom? David Zimmerman?

MR. DUNN: Yes.

THE COURT: Entitled, "Patients on Methadone left Hungry for a High", by David Zimmerman, the Journal of the Addiction Research Foundation, June 1, 1973, Defendants' Exhibit J for identification. Is there an objection?

MR. BALBER: There is, your Honor.

THE COURT: Sustained. If you want to call Mr. Zimmerman, you can call him.

What else do you want to ask?

Q Dr. Lynch, does methadone have an effect on the ability of a person to operate machinery?

A As a central nervous depressant, sedative, hypnotic, narcotic, analgesic, yes, I would say so.

A I have not had an opportunity to subject her

Q Does it have an effect on a person to perform clerical operations?

A It depends on the nature of the operation, as I would assume.

MR. BALBER: Your Honor, I object to assumptions by the witness if he has facts.

THE COURT: He has a feeling, in a manner of speaking. If there is one answer that you shouldn't have objected to, it is that one. I would be glad to sustain any objection.

MR. BALBER: I will withdraw the objection.

Q Do you have an opinion, doctor, as to whether the person on methadone is as dependable and reliable as the person who is not taking methadone?

MR. BALBER: I object to that, your Honor.

MR. DUNN: I am only eliciting whether or not the doctor has an opinion.

MR. BALBER: The opinion is irrelevant. It depends on the doctor's expertise.

THE COURT: Have you observed a lot of methadone patients?

THE WITNESS: Yes.

THE COURT: Closely?

THE WITNESS: Yes.

THE COURT: I assumed he had. I will hear it.

Q Do you have an opinion as to whether or not the methadone patient is as reliable or less reliable or more reliable than the person not taking methadone?

A I would say his degree of dependability is less than the normal person.

Q Are you familiar, doctor, with the tests that are administered to measure the psychomotor response of an individual, the rotary pursuit test?

A I'm familiar with that test, yes.

Q Are the tests valid predictors of whether a person can adequately perform duties involving the operation of machinery?

A It doesn't have to be relevant at all.

THE COURT: I don't understand the answer.

What is the name of the test?

MR. DUNN: Rotary pursuit test or other tests used to measure --

THE COURT: That is the test we have evidence about earlier?

MR. DUNN: Yes.

THE COURT: I don't understand your answer.

THE WITNESS: It doesn't predict an individual's ability to operate machinery.

THE COURT: Why not?

THE WITNESS: A person may perform successfully on that test if he is under the influence of a drug, but not be able to make a judgment which is quickly required. I would say that in the case -- I withdraw that. That was speculation.

THE COURT: You are saying a person could perform successfully on that task but still not be able to do what?

THE WITNESS: To operate a milling machine or a lathe or devices of that nature, motor vehicles.

pm THE COURT: What would be lacking when it came to operating a machine?

THE WITNESS: This test doesn't really do very much about determining decision-making and ability of an individual to make a decision. It indicates some degree of manual dexterity.

THE COURT: I guess I thought I knew what the psychomotor test was. We had a Dr. Gordon who submitted a statement. He said:

"There is an input signal consisting of a small circular target which rotates in a fixed path on a turntable and was set to rotate at a speed of 60 rpm, which gave the center of the target a linear speed of

22 inches per second. The task of the patient was to bring the tip of a hand stylus into contact with the target and maintaining contact by means of a rotary motion of the hand and form at the same rate as that of the target. Underlying the simplicity of this test is completion factors which are relevant to a number of other skills."

Does it simply test the ability of somebody to focus and keep his hand and eye moving and keep whatever it is on the target and it does not test his ability to do what a lathe operator would be required to do?

THE WITNESS: That is my opinion.

THE COURT: Just enlarge on that.

THE WITNESS: We use in our laboratories an analogous test to measure psychomotor deficit.

THE COURT: To measure what?

THE WITNESS: Psychomotor deficit. In other words, the administration of a drug producing a degree of either central nervous system stimulation or central nervous system depression that would interfere with the motor coordination.

THE COURT: How is that different from the psychomotor test?

THE WITNESS: Because -- it is really not different.

THE COURT: Why do you tell me about it?

THE WITNESS: Because this is a test that we use with animals. There is no judgment involved in the reacting in the test. I can train animals to do exactly the same thing with lights.

THE COURT: In other words, you are saying you could train an animal to do a psychomotor test?

THE WITNESS: Yes, sir.

THE COURT: All right.

Q Is the psychomotor test, doctor, in any way a predictor of a person's reliability as an employee in any capacity?

THE COURT: If what he says is true, then it does not. Let's not belabor the point.

What else do you have?

MR. DUNN: Just this, your Honor. In view of the hour and the cross-examination that is anticipated of the witness, I would like to reserve, with the Court's permission, my right to recall Dr. Lynch after Dr. Gearing testifies.

THE COURT: That is all right.

MR. DUNN: And also to note for the record that the cross-examination of Dr. Gordon had not been completed and I would like some time at the Court's convenience to continue the cross-examination.

THE COURT: Certainly.

MR. DUNN: Thank you, your Honor.

CROSS-EXAMINATION

BY MR. BALBER:

Q Dr. Lynch, how many studies have you published on the effect of methadone on the human body?

A The effect of methadone on the human body?

Q Yes. How many studies have you published in that area?

A None.

Q How many studies have you published on the effect of methadone on laboratory animals?

A We have currently a publication that is submitted but not published.

Q You have one article submitted but none that are published.

Dr. Lynch, have you ever treated a methadone patient clinically?

A I'm not a medical doctor.

MR. DUNN: I object. Dr. Lynch is not a physician. He is a pharmacologist.

THE COURT: Overruled. What is the answer?

THE WITNESS: I'm not a medical doctor.

Q Have you ever observed methadone maintainees on a day-to-day basis for as long as two months?

A Yes.

Q The same people day-to-day for two months?

A Yes.

Q Six months?

A Not continuously, no.

Q A year?

A Continuously, no.

THE COURT: In the beginning of that series of questions you said you observed what?

THE WITNESS: I observed on a day-to-day basis methadone maintainees two months, which was the question. My answer was yes.

THE COURT: The same methadone patients?

THE WITNESS: Yes. On a day-to-day basi. for six months, the same patients, no, or for a year, no.

THE COURT: But you have for two months?

THE WITNESS: Yes.

THE COURT: What was the occasion for these observations and what was the nature of these observations?

THE WITNESS: Participation in the studies that I did for the Legislative Committee and also during the past summer I had the opportunity to participate in a clinical residency.

THE COURT: Where?

THE WITNESS: At Cornell Medical Center, North Shore Hospital. In part each one of those days was spent in the methadone program there.

THE COURT: Last summer, you say. Can you give me the name of the installation again?

THE WITNESS: Cornell University Medical Center, North Shore Hospital.

THE COURT: Where on the North Shore?

THE WITNESS: It is Manhasset.

THE COURT: Do they have a methadone maintenance clinic?

THE WITNESS: They have methadone maintenance and detoxification programs.

THE COURT: Each day you went to both?

THE WITNESS: They are in the same facility.

THE COURT: What programs did you observe in 1970 and 1971 when you were working for the Legislative Committee?

THE WITNESS: At that time there was a program in Bay Shore. It is no longer in operation.

THE COURT: Where is Bay Shore?

THE WITNESS: Out on Long Island.

THE COURT: What was that program?

THE WITNESS: That was a methadone maintenance program that was of a -- under the auspices of the Narcotic Addiction Control Commission at that time.

THE COURT: Did you observe any other programs at that time?

THE WITNESS: Yes. We observed the program at Beth Israel Hospital and a program in Albany.

THE COURT: All right, Mr. Balber.

Q Dr. Lynch, are you familiar with the studies of Dr. Gordon on reaction time?

A No, I'm not.

Q Are you familiar with the studies of Dr. Gordon on the IQ of persons maintained on methadone?

A Dr. Gordon's work is somewhat outside of my field.

Q What field is that?

A Of psychology.

Q Psychology is out of your field?

A Yes.

Q How do you know then that people on methadone have psychological problems?

A The literature tells me that.

Q What literature?

A The literature involved with methadone.

Q Can you name some of the authors?

A Yes, Dr. Dole and Dr. Nyswander talk about the psychopathogy of the methadone addict.

Q What other authors can you name? Can you name some more?

A Yes, Chambers and Ball. Brill and Chambers, as a matter of fact, have written a book. I have copy of it in my briefcase. It is entitled, "Methadone," published by Charles C. Thomas.

Q And have these studies told you that the longer people are in treatment the more emotional problems they have?

A Yes, they do.

Q Dr. Dole's works supports that?

A I didn't say Dr. Dole specifically. Some of the work that I have read supports that contention.

Q Are you familiar with a study released by the National Highway Traffic Safety Administration about a year and a half ago on the driving performance that people maintained on methadone?

A Yes. That was the study that was involved, I believe -- if I'm correct in my recollection, that is a study that was involved with people in the New York program where they did a study of comparison between accidents occurring among so-called normal non-drug taking populations and methadone treatment populations.

Q Are you familiar with a similar study that was done by Dr. Gordon on the New York City methadone maintenance treatment population?

THE COURT: What was the first study you mentioned?

MR. BALBER: That was the study Mr. Blomberg testified about.

THE COURT: A study by whom?

MR. BALBER: It was a study of the National Highway Safety Administration done by Dunlap, the subject of Mr. Blomberg's testimony.

Q Are you familiar with a similar study done by Gordon on the New York maintainee population?

A I believe there was a study that indicated that there was no significant difference between the two groups, yes.

Q Have you done any similar studies, Dr. Lynch?

A Have I done studies on driving?

Q Yes.

A No.

Q Have you done any studies that indicate that the people maintained on methadone are unreliable in complex psychomotor situations?

A No, I have not.

Q Are you aware of any such reliability studies and who did them, if you are?

A I'm not familiar with any reliability studies. Productivity.

Q Dr. Lynch, you stated that you visited methadone maintenance programs and talked to people in such programs. Have you ever done studies of the people in such programs, statistical studies taking large random statistically valid samples?

A I have studied the statistics produced by other people.

Q And who are those people? You mentioned Chambers and Ball. Who else?

A Preliminary studies that were produced in, I believe, about 1968 by Dr. Dole and Dr. Nyswander and then there were the reports produced or the evaluations produced by the American Medical Association of the Dole and Nyswander studies.

THE COURT: You are talking about what study?

MR. BALBER: Talking about any studies that he knows of. The witness stated he has done no statistical study of --

THE COURT: Reliability.

MR. BALBER: -- of the general characteristics. I can break it down, if you like, but I thought I could shorten things a bit.

Q You mentioned that Dr. Dole did a study, Chambers and Ball. Who else?

A Chambers and Brill, I also mentioned. I would have to refer --

Q Dr. Lukoff?

A The name I have heard, yes, in reference to methadone.

Q Do these studies support the proposition that persons maintained on methadone aren't reliable? Did Dr. Dole's studies support this proposition?

A Quite the contrary.

Q Did Dr. Lukoff's studies support this proposition?

A I would say no.

Q Did you testify that Dr.Gearing had done studies as well?

A No, I did not.

Q Has she?

A I have seen her report, yes.

Q Do her reports support the proposition that people maintained on methadone are unreliable?

MR. DUNN: I object. The witness did not testify that he reached that conclusion from the reports or studies.

MR. BALBER: The witness testified he has done no studies.

MR. DUNN: My recollection is that the witness testified to the contrary.

THE COURT: He gave his opinion. That is all right. You are asking about his opinion as to the reliability; right?

MR. BALBER: Yes, your Honor, at this point.

THE COURT: Go ahead.

Q Do Dr. Gearing's studies support the proposition that people or methadone, everyone on methadone, is unreliable?

A I have had the opportunity to glance at Dr. Gearing's report.

Q You just glanced at her report?

MR. DUNN: May the witness complete his answer before he is asked a technical question?

THE COURT: Yes.

MR. BALBER: I'm sorry.

A I have not had an opportunity to subject her report to any detailed analysis or study, but I would judge from what I have read and the conclusions that are drawn that she believes that there is a high potential for reliability.

Q Are you generally aware of the literature in the reliability area of the methadone maintained population?

A I have tried to keep myself informed.

Q Are you aware that Dr. Gearing has been publishing periodic reports in this area since 1965?

A Yes, I am.

Q Are you aware that she has published at least a dozen such reports?

A Yes, I am.

Q And you just had an opportunity to glance at only one of her reports?

A At the report that was submitted here.

THE COURT: What we have had here in this case that constitute studies about reliability, specifically relating to reliability. Have you produced any studies in this case on the subject?

MR. BALBER: Dr. Gearing's report is a comprehensive report.

THE COURT: I don't see anything in her report that says anything as to reliability or unreliability.

MR. BALBER: I think that Dr. Gearing -- she will give testimony as to what her report says. I will stop with this line of inquiry.

Q You stated that as a person is in the methadone maintenance treatment program his tolerance to methadone continually increases. Is that a correct statement of what you said?

A Yes, it is.

Q Have you done any studies of human beings that support that opinion?

A To date, no.

If I might add, your Honor, something that is not an opinion?

THE COURT: What is that?

THE WITNESS: In all of the programs that I am aware of the dose that the patient is put on is chosen at a certain point, say, ten milligrams twice a day. I know because I'm currently involved in a research program of this nature, that blood levels are not determined to find out how methadone remains in the body, at what levels methadone remains in the body. I don't think that there is anybody who can answer the question the way that you want the question answered. There are no programs currently that are evaluating or assessing blood levels of methadone in methadone maintenance patients.

THE COURT: That really wasn't his question.

Are you going to pursue this?

MR. BALBER: The witness had made a statement, a very flat opinion earlier in his testimony, that people on methadone developed increasing tolerance to methadone. I asked him if there were any studies on human beings to support this proposition.

THE COURT: I just want to know if you are going to ask him any more questions.

MR. BALBER: If the witness answers no --

Q What is your answer to that question?

A Increasing the tolerance.

Q Increasing the tolerance. Are there any studies on human beings to indicate that this in fact is the case with anyone on methadone maintenance treatment?

A Not to date, simply because no studies have been done.

THE COURT: What puzzles me is that you are assuming that in order to take account of that fact the methadone maintenance program should increase its dosage.

THE WITNESS: Right.

THE COURT: Now, the impression I have had, and I am trying to look over some notes now, is that this is exactly the opposite of what is done, and I really find that puzzling. We had a Dr. Cushman who testified that initially at his St. Luke's program there was a high dose. Then after about a year there was a reduction to what he called a comfortable dose, which can be anywhere from two milligrams to one hundred, and I did get the impression all the way through that we were talking about stabilization which meant putting the people on the same dose or, if anything, reducing the dose. Isn't that what the programs do?

THE WITNESS: The guidelines under which the programs currently operate have a maintenance dose between 80 and 120 milligrams per day.

THE COURT: You are talking about those FDA guidelines?

THE WITNESS: Yes.

THE COURT: Do the FDA guidelines provide that there should be a stabilization on a certain dose?

THE WITNESS: Yes.

THE COURT: And that dose should remain the same?

THE WITNESS: Yes.

THE COURT: And whatever it is it should remain the same; right?

THE WITNESS: Yes.

THE COURT: So doesn't that conflict with your opinion as to what should happen?

THE WITNESS: It conflicts to a degree. We are talking about something that has not withstood the test of time. I am not professizing. I am indicating on the basis of facts that we are already familiar with, with analogous drugs, that there must be in the future in this maintenance program an increase in dosage if we are going to maintain a successful response.

I furthermore stipulate that the reason why some people -- a proportion of the methadone maintenance patients are going to other drugs and going to alcohol is because of this very fact. The methadone is not supplying their very basic needs at that stabilized dose.

THE COURT: Don't we need to get facts about how methadone patients do go to alcohol or other drugs and when? The thing is, you are talking on the basis of a medical opinion, so to speak.

THE WITNESS: Right.

THE COURT: Now, if your opinion would be that a stable dose would create this increased tolerance --

THE WITNESS: Yes.

THE COURT: -- then that in theory that would increase the need for more methadone or some substitute; right?

THE WITNESS: Yes.

THE COURT: And in theory the man should either get his methadone or else he is going to get, maybe, a substitute?

THE WITNESS: Yes.

THE COURT: Now, in practice what can you tell me or can you give me any information that either bears out your theory or doesn't bear it out that derives from actual experience?

THE WITNESS: Your Honor, we are making measurements of that type in our laboratories at the current time and the evidence that we have seems to indicate that this is what is happening, but I would not --

THE COURT: What evidence is that?

THE WITNESS: That the subjects are demonstrating increased tolerance.

THE COURT: How do you measure that?

THE WITNESS: By measuring their degree of irritability and the way in which they present themselves for treatment.

THE COURT: How many subjects are you working on?

THE WITNESS: We have a very small population at the present time.

THE COURT: How small?

THE WITNESS: I would say about one hundred and sixty-five people that are involved in this.

THE COURT: And how long have they been on methadone -- different periods?

THE WITNESS: Different periods of time. This is part of the problem.

THE COURT: Have you got a group who have been on methadone for, say, more than six months?

THE WITNESS: Not a group. Some of them have been on -- individuals have been on more than a year, but --

THE COURT: How many have been on more than a year?

THE WITNESS: I would have to give you only an approximation.

THE COURT: Approximate.

THE WITNESS: A dozen.

THE COURT: Twelve people over a year?

THE WITNESS: Yes.

THE COURT: Are those people enrolled in some methadone maintenance program?

THE WITNESS: Yes.

THE COURT: And have they been for some time on a stable dosage of methadone?

THE WITNESS: Yes.

THE COURT: Have you observed, then, as to what is happening to them in the ways you have been speaking about?

THE WITNESS: Yes.

THE COURT: What is your observation?

THE WITNESS: That their performance is somewhat eratic.

THE COURT: What do you mean by eratic performance?

THE WITNESS: If, for example, the patients present themselves at a methadone maintenance program, in this particular methadone maintenance program, the patient is required, for example, to give a urine sample for the purpose of determining whether or not that patient is currently taking other drugs in addition to methadone, whether he is taking his methadone and if you look at the statistics, the data as it comes back from the laboratory, you find that for a period of time a patient will be drug-free taking his methadone. Then, all of a sudden you find other drugs being detected in the urine sample.

THE COURT: I am talking about these twelve. Can you tell me this: Are there other drugs being detected in their urine samples?

THE WITNESS: Periodically. Maybe --

THE COURT: There are?

THE WITNESS: Yes.

THE COURT: Do they manifest any withdrawal symptoms of the kind you were talking about or incipient withdrawal symptoms, the irritability, the twitching or whatever it is?

THE WITNESS: Nothing as gross as twitching.

THE COURT: Anything at all?

THE WITNESS: A person who today was very calm and relaxed and easy to talk to, tomorrow may be sharp in his answers and that sort of thing.

THE COURT: That is what you mean by eratic, irritability; is that what you are talking about?

THE WITNESS: Yes.

THE COURT: Had you observed these symptoms in these twelve men on the program over a year?

THE WITNESS: In one or two, yes.

As I say, in one or two individuals, periodically you'll get this kind of response. They will describe their response in this way:

"You know, I feel kind of apprehensive about what is going to happen when I -- you know, just exactly how am I going to be able to cope?"

That is all. Anxiety.

THE COURT: I'm sorry, Mr. Balber.

MR. BALBER: That is all right, your Honor. It is quite helpful,

Q Is it one or two people out of the twelve?

A Yes.

Q What types of situations do they have problems coping with, difficulty coping with?

A Jobs, family, school.

Q Day-to-day affairs?

A Yes.

MR. BALBER: That concludes our cross-examination your Honor.

THE COURT: Any redirect? Do you reserve the right to recall him?

MR. DUNN: Just one point, your Honor, which will take no more than two or three minutes.

REDIRECT EXAMINATION

BY MR. DUNN:

Q Dr. Lynch, you testified, I believe, on cross-examination, that you are familiar to some extent with the tests that measure the productivity of individuals maintained on methadone. Can you elaborate on that?

A The attorney who has been cross-examining him asked me about my knowledge of a test or studies concerned with reliability. I brought up the term productivity in correcting him. I do not know of studies concerned with reliability. I do know of studies where they used the term productivity.

Q Which studies are those, doctor?

A Specifically, for example, the study of Dr. Gearing that I saw this morning.

MR. DUNN: Thank you. I just wanted to clarify that.

THE COURT: That is all.

[Witness excused.]

MR. BALBER: Plaintiffs would like to call Dr. Gearing to the stand, please.

CARL A. BEAZER, et al,
Plaintiffs,
vs.
NEW YORK CITY TRANSIT AUTHORITY,
Defendant.

72 Civ. 5307

New York, February 3, 1975.

Trial resumed.

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VINCENT D. LYNCH, called as a witness on behalf of the defendant, being first duly sworn, testified as follows:

MR. DUNN: Your Honor, at this time I offer as a defendant's exhibit for identification DDD which has been stipulated to by both defendants and plaintiffs to represent a partial description of the chemicals used by TA personnel.

THE COURT: All right.

MR. DUNN: I offer Defendant's Exhibit EEE, which is an authenticated copy pursuant to the provisions of Rule 44 of the Federal Rules of Civil Procedure, authenticated by the Food & Drug Administration, containing the labeling of a package insert of the drug dolophine hydrochloride, which is methadone, the labeling,which was approved on March 22, 1973; the labeling approved February 4, 1972; the labeling approved November 6, 1970, and the labeling approved December 23, 1955.

THE COURT: Any objection?

MR. BALBER: Yes, your Honor, I object to EEE except insofar as it is proof of the fact that labeling exists, not as proof of any matter asserted therein.

THE COURT: What is this?

MR. DUNN: This, your Honor -- and I think Dr.

Lynch would be in the best position to testify what the labeling represents -- I would be happy to if the Court wants, but I think Dr. Lynch is the one who has the expertise.

THE COURT: This is EEE?

MR. DUNN: Yes.

THE COURT: What is the purpose of offering this, Mr. Dunn?

MR. DUNN: The purpose of offering this, your Honor, is twofold: the drug methadone is required to be accompanied by this package insert when it leaves the manufacturer when it is addressed to the dispenser.

The package insert contains government-prescribed language, language which must be submitted to and approved by the Food & Drug Administration, which sets forth the use or usage, the cautions, the contrary indications, the adverse reactions, the side effects of the particular drug.
3 This has been amended from time to time. There is a cautionary note that is prefaced "Use in ambulatory patients."

That change appears to have taken place in 1970 in response to a Federal Register notice of August 26, 1970, a copy of which I have here.

The purpose, or one of the purposes of offering that is to show that after 15 years of use the Food & Drug Administration saw fit to require the manufacturer to include an additional caution which cautions against the use of methadone in ambulatory patients, and requires that patients be warned not to operate a car or machinery or engage in potentially hazardous tasks.

I have a letter which accompanied that document --

THE COURT: I don't understand. I have got Exhibit D and I have got Exhibit A, Exhibit B, and I suppose some of this you mean to have labeled Exhibit C but it is not --

MR. DUNN: If I may invite the Court's attention --

THE COURT: Oh, yes, I see Exhibit C.

MR. DUNN: May I invite the Court's attention to Exhibit A.

THE COURT: Yes?

MR. DUNN: There is the first page which says "Dolophine Hydrochloride." Just lift that page up, and in the lefthand column on the page following --

MR. BALBER: Excuse me, your Honor, but can I see a copy from which I can follow this?

THE COURT: Of course.

(Copy handed to Mr. Balber.)

THE COURT: Go ahead, Mr. Dunn.

MR. DUNN: About two-thirds of the way down, Judge -- and this is under the cautionary portion -- it states: "Use in ambulatory patients. Methadone may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks, such as driving a car or operating machinery. The patient should be cautioned accordingly."

For 15 years the FDA approved a package insert without this, and in 1970,as a result of 15 years of experience with the drug, then required the manufacturers to insert and to retain this warning in a package insert which accompanies every shipment of methadone to the dispenser.

THE COURT: That is your statement. If it has that significance shouldn't we have testimony about that?

MR. DUNN: Dr. Lynch is here and prepared to testify.

THE COURT: Is he with the FDA?

MR. DUNN: No. I have an accompanying letter from the FDA which may be of assistance to the Court, and if necessary he can subpoena the head of the new drug application section of the Food & Drug Administration.

THE COURT: Mr.Dunn, it's a very important issue. If you are going to contend that there are effects of methadone which impair the mental and physical abilities such as in driving a car or operating machinery, that's very important in this case.

MR. DUNN: It is important to the defendant, too, your Honor. Very important.

THE COURT: I wasn't implying the case wasn't important to the defendant.

But again we have the same problem to prove an important fact by sticking in some piece of paper like this is not the way to do it. The FDA, if they have somebody or if we can get somebody who can be subjected to cross-examination to explain in some way that they are eligible and capable of explaining that this is true, well, then they can certainly testify. But I could not possibly permit the proof of that kind of fact on the basis of this piece of paper. I couldn't do it.

MR. DUNN: Your Honor, may I just very briefly state my position on this:

The Court had the benefit of Dr. Dupont who narrated Federal policy with respect to methadone. It is my contention that the Court similarly should have the benefit of a representation by the Food & Drug Administration as to what the Federal policy and the Federal findings are and what the required cautions are with respect to methadone, and this document speaks for itself as an expression of that government action, that agency's action.

THE COURT: I will not receive it for that because it could be that the person who wrote this or approved it, on cross-examination might reveal certain things that would throw light in someway upon this, maybe take away from the effect of it as far as a fact. We have seen this repeatedly in this case where people have referred to studies, and this and that in print, and we have seen constantly how the witnesses who know about these studies will amplify, modify or do something about it.

So I will not receive this exhibit to prove anything more than the fact that the Food & Drug Administration does what it says. I will not receive it for the proof that methadone may impair the mental and/or physical abilities required, and so forth. It does not prove it to me.

MR. DUNN: The purpose, your Honor, of offering this is to show that the Food & Drug Administration requires that dispensaries or users of methadone be advised as to this caution, just that they be advised as to the caution.

THE COURT: And what do you want me to infer from that? That it has its dangers, right?

MR. DUNN: Your Honor, among other things, that if the New York City Transit Authority were to knowingly employ a methadone patient in a potentially hazardous task, that this representation by the Food & Drug Administration would very seriously impair the Transit Authority's ability to defend a tort action based on negligence of a methadone patient.

THE COURT: Well, I will receive it to show that this labeling is required and whatever significance that fact has. But I will not receive it to show that, indeed, methadone has these effects. So I will receive it on that basis.

DDD and EEE are received.

(Defendant's Exhibits DDD and EEE for identification received in evidence.)

DIRECT EXAMINATION

BY MR. DUNN:

Q Dr. Lynch, among your other qualifications you are a pharmacologist, are you not?

A Yes.

Q Are you familiar with package inserts in general?

A Yes.

Q Can you describe for the Court and myself what the term "package insert" refers to?

A According to Federal regulation every prescription drug manufactured in the United States has to meet a certain requirement with regard to warnings and precautions that are made available to the presiding physician. That actually constitutes the package insert. It consists of a document that describes the chemical constitution, the forms that are available, the contrary indications, the precautions, the cautions, the adverse reactions, as well some some of the indicated uses.

As I say, every prescription drug that is manufactured in the United States must be accompanied by this particular type of document, and the information that is contained therein is supplied in part by the manufacturer, but it is approved finally by the FDA.

Q Must the package insert be verbatim that which was applied by the Food and Drug Administration?

A Absolutely.

Q Dr. Lynch, I invite your attention to Defendant's Exhibit DDD. That exhibit is a partial inscription of chemicals used by Transit Authority personnel.

Would you Doctor, go down the list of chemicals that are contained on that exhibit and tell us whether or not in your opinion any of these chemicals would be synergistic or would their effects be potentiated by the use of methadone concurrently with being exposed to these chemicals; and if so, to what extent?

THE COURT: Can I see DDD for a minute?

(Handing.)

MR. DUNN: I have another copy, your Honor, if that would be of assistance.

A To my knowledge, a potentiating effect would occur in the first agent methylene chloride; in the second, methylene chloride; in the third, freon-12 and methylene chloride; in the fourth, cellosolve; in the fifth, methylene chloride, ethanol, acetone, aromatic mineral spirits; in the sixth, isopropyl alcohol; in the seventh, methylene chloride. In the eighth, methyl alcohol and methylene chloride; in the ninth, butyl cellosolve cyclohexanol;

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in the tenth, cellosolve and cellosolve acetate; in the eleventh, dichlorobenzene and isophorone; in the twelfth, methylene chloride, toluene; and in the last, cellosolve acetate and commercial xylene.

I'm sorry, there is a fourth page. In the first item on the fourth page, acetone and toluene; and in the second, toluene and methyl isobutyl ketone.

All of the agents that I have mentioned are central nervous system depressants and would have an effect in concert with or potentiating effect of methadone. The compounds listed as methylene chloride--methylene chloride per se is a chemical relative of chloroform, and methylene chloride has sometime in the past been used as a volatile anesthetic for inhalation purposes.

The other compounds are only used commercially as solvents or things of that nature, except in the case of ethanol, which is ethyl alcohol. It finds many medical uses, as a solvent and also as an antiseptic.

But the others are primarily solvents of a commercial variety.

Q Can you describe what the effect would be on an employee who was exposed to one of these chemicals that you have indicated?

A Well, certainly the effect would depend upon the concentration in the atmosphere in which the individual was found to be at that particular moment. There are minimum acceptable limits that are set on the concentrations, and since I don't know what the concentrations would be in any one of the, you know, shops that these materials are used, I really can't make a definitive statement.

But if the concentrations were above the mininal acceptable concentrations which in many instances are quite low, the effect would be varying degrees of central nervous system depression.

Q That would manifest itself how, Doctor?

A Dizziness, a dizziness, light-headedness, inability to function physically in a coordinated way.

Q Respiration being depressed?

A There would be in the case of certain of these agents respiratory depression. I would mention specifically toluene, I would mention specifically methyl isobutyl ketone, commercial xylene, and methylene chloride.

Q Would these effects be potentiated by methadone?

A Yes, I would judge that in the case of an individual who had methadone in his system that the effects would be potentiated more than maybe anticipated with the solvent alone.

Q What would the effect of this potentiation be?

A Again, a heightened or deepened central nervous system depression, deepened respiratory depression. Again, all of the physical and mental facilities would be impeded.

Q The Transit Authority doctor was very careful to insure that the maximum concentration, maximum allowable concentration of these chemicals is not exceeded in an employment situation.

Would it be a hazard for an employee sustained on say 100 milligrams daily dose of methadone to be exposed to these chemicals in a usual work atmosphere?

A I would have to say yes, that the methadone, the individual methadone would have more of a tendency to respond to the depressant action of these compounds than would be the individual who was not on methadone.

Q Doctor, is that statement contradicted by the package insert or is it in consonance with the package insert?

A It's very much in keeping with what's said in the package insert.

You pointed up, if I might indicate, you pointed out use in ambulatory patients methadone may impair the mental and/or physical abilities required. This is methadone alone. I would rather point out that there are statements here which indicate that there is an interaction, this would be on again that item that you referred to.

MR. BALBER: Objection.

THE COURT: Sustained. What is the next question?

Q In your opinion, Doctor, does alcohol have a potentiating effect on central nervous system depressants?

A Yes.

Q On what do you base that, Doctor?

A The evidence that has been accumulated through a great deal of research.

THE COURT: Is this the question about whether alcohol has a potentiating effect?

MR. DUNN: Methadone has a potentiating effect on alcohol, is the question.

THE COURT: Haven't we had that?

MR. DUNN: Yes, but it's terribly significant to know in view of the testimony we had at the last two sessions.

THE COURT: It wasn't less significant then. I don't think we ought to be repeating ourselves. I think we covered that before.

Q Have there been experiments, is the potentiating effect that you refer to between methadone and alcohol, is that a theoretical or is the result of theoretical considerations or have there been experiments performed which establish the potentiating effect?

A No, this is a result of experimentation and human evidence that began to be accumulated as far back as the early, middle '50s.

The use of methadone at that time at the United States Public Health Service Hospital in Lexington was as an agent used in detoxification of the heroin addicts, and at that time I would have to refer to a specific document, but at that time the director of the program indicated that there was a significant interaction between alcohol and methadone.

This is consistent with the findings recently of the New York State Drug Abuse Control Commission. Last year they conducted a study among the methadone maintenance patients in New York State and alcohol consumption is becoming an acute problem.

Q Are you yourself conducting experiments at this time, Doctor?

A Yes, we began to--

Q By we, you are referring to St. John's University?

A Myself and my colleagues at the university. Because of this particular case, as a matter of fact, we became interested in the possibility of the interaction of methadone with a variety of other substances of a central nervous system depressant nature, and about three weeks ago we set into motion a project where we were going to study the substances that an individual on methadone might come in contact with by way of environment or atmosphere, or what have you.

Q Were you including in that experiment some of the items on the list in front of you?

A Yes, some of the representative items here. Methylene chloride and the similar types.

THE COURT: You said something about alcohol; did you say alcohol was becoming an acute problem with methadone patients?

THE WITNESS: With methadone maintenance patients.

THE COURT: What do you mean by that, and what's the source of your information?

THE WITNESS: There was a study conducted by the New York State Drug Abuse Control Commission last year. I'd have to give you the exact reference. But the consensus of the findings was that a large number of patients on methadone were now turning as well to alcohol, and an acute alcoholism or chronic alcoholism is becoming a problem among people on methadone.

THE COURT: When you say a large number, what were the figures?

THE WITNESS: The figures, your Honor, represented around 40 or 50 per cent of the patients that were studied.

T5

Q The results of your experimentation, are they available at this time?

A No, they have just begun. I would not anticipate any results for six months.

Q Would you consider it hazardous, Doctor, for a methadone maintained patient to be exposed to the chemicals on the list you have just read?

A Yes, I would.

MR. DUNN: I have no further questions.

CROSS EXAMINATION

BY MR. BALBER:

Q You mentioned alcoholism and a methadone study that you just started in connection with the Transit Authority?

A Excuse me, I didn't say alcoholism and methadone. I indicated I started a study concerned with the exposure of animals to methadone in combination with some of the items on this list. Did the Transit Authority ask me to start this stury? No.

Q What kind of animals, Doctor?

A We are going to be using the routine laboratory animals -- rats, mice.

Q Do you have any studies in progress involving the use of alcohol by human beings maintained on methadone?

A No.

Q Dr. Lynch, how many studies have you done on the interaction between methylene chloride and methadone?

A None.

Q Doctor, how many studies have been done by other persons involving methylene chloride and methadone?

A None.

Q Refresh my basic chemistry on methylene chloride. It is basically two carbon atoms drawn by a double bond?

A No. Methylene is CH_2 CL_2. The compound you are referring to is ethylene dichloride.

Q Can you explain to me what happens chemically and what the interaction is between that drug and methadone?

A Methadone?

Q Right.

A Methylene chloride is the next lower chemical analog of chloroform. Chloroform is $CHCL_3$. Methylene chloride would act in exactly the same way. These compounds are halogenate hydrocarbons and they had the tendency to concentrate in nerve tissue, particularly initially in the cerebral cortex.

Q Methylene chloride does?

A After it is absorbed in the circulatory system it enters the brain tissue.

Q But if you have done no studies and no one else has done studies, how can you make that statement?

A We have studied methylene chloride. No studies have been gone to my knowledge on the combination of methylene in combination with methadone.

Q So these studies show that methylene chloride is a central nervous system depressant?

A Yes.

Q But you have done no studies between that and methadone?

A Right.

2 Q Docto, freon 12, how many studies have you done on the interaction between freon 12 and methadone in human beings?

A No studies on the interaction of methadone and freon 12, but I have discussed the toxicity of freon 12.

Q Have other people done studies on the interaction of freon 12 and methadone?

A I don't know.

Q Is freon 12 a central nervous system depressant?

A Yes. It is used as a propellant in various aerosol preparations and also as a refrigerant.

Q But you have never studied freon 12 and methadone together?

A Not in combination.

Q Cellosolve, isn't that a brand name?

A That is a brand name for a petroleum distillate used as a solvent.

Q What is the chemical composition of that?

A It is a complex hydrocarbon for which no specific formula has been stated.

Q How does this chemical compound affect the body?

A Like its other chemical relatives, they are central nervous system depressants.

Q Have you ever studied the effect of Cellosolve on human beings?

A No.

Q On rats?

A On rats.

Q Has anyone that you know studied the effect of Cellosolve on human beings?

A Cellosolve per se? Yes.

Q Has anyone, including yourself, studied the interaction of Cellosolve and methadone?

A No.

THE COURT: This is probably a silly question, but I'm not asking it to be silly. Have you made any observations of the conditions under which these compounds are used in the Transit Authority, whether it is out in the open air or in a closed building or any of those conditions?

THE WITNESS: I really haven't been able to ascertain under what conditions. The only thing I do know is having observed some of the photographs that were shown to me, the conditions.

THE COURT: What photographs did you see?

THE WITNESS: I saw photographs of men cleaning parts and so on in a large shop-like room and I also saw men cleaning the graffiti on platforms and things of that nature.

THE COURT: Who showed you those pictures?

THE WITNESS: The last appearance we had in court the pictures were taken when you traveled on the subway station.

THE COURT: Did we get pictures of that?

THE WITNESS: You had pictures of the shops and the platforms. I was told that these were the conditions under which these materials were being used.

THE COURT: I can understand how you could conclude that methadone and one of these compounds under certain circumstances would be what you say, but doesn't it depend upon the amount of this other substance, the conditions under which it is used, how much it is diluted, how much fresh air there is, all these other things.

THE WITNESS: Yes, your Honor, all of these factors have to be taken into account. A suitable study would undertake an analysis of a fashion. The concentration of these materials, the varying concentrations of these materials in a variety of different atmospheres.

THE COURT: Would the best way to find out be to take a person on methadone and have him do this work and ask him, "Do you feel dizzy? Do you feel any effect?" And if you are worried about whether he is a good enough sample or telling you the truth, you take another man and do the same.

THE WITNESS: That would be a reasonable thing, your Honor, provided certain other parameters were measured as well. In other words, a person who has taken methadone or any other drug may have specific effects as an individual from that particular drug. You take that individual and ask him a question at some period of time, "How are you feeling?" And the answer that comes back may not be referable to the drug that he has in him, and it may not be referable to the drug in combination with the atmosphere. Yes, sir, I would undertake a study like that provided not only would

I be allowed to question the individual, but also I'd be allowed to take blood samples, urine samples, and also the sample of the atmosphere in which he is working. Those are all pertinent.

THE COURT: I am not asking you to undertake this. But sitting here and looking at the sheet and knowing what you now know, are you really able to say what would happen if a methadone patient performed a particular cleaning operation for the Transit Authority out in that yard at Coney Island?

THE WITNESS: I believe I would be able to say under the circumstances, the concentration of the material in the air, if it exceeded, for example, in the case of acetone --

THE COURT: Where is acetone?

THE WITNESS: Acetone is a very common as a solvent. It is on page 2, the top group. In the case of acetone if the concentration exceeds the allowable concentration, then I would assume immediately that a person exposed to that atmosphere for a short period of time, a normal person, would become dizzy, would become light-headed, would fail to function properly, and I would assume then consonant with what I think a person who is under the influence of methadone, he would probably react even faster.

THE COURT: Before it even got to that degree.

THE WITNESS: And I could same the same with respect to these other compounds, because they are even more potent. The maximum allowable concentration, for example, of methylene chloride is approximately 200, 250 parts per million; the maximum allowable for xylene and toulene is 5 parts per million. b3

The maximum allowable concentration means that a person should not be exposed to this atmosphere containing these concentrations for an unreasonable period, a half an hour.

THE COURT: Well, do you know anything about the concentration in the air which exists during a normal use of, let's say, turco-800 in a car cleaning operation or railroad porter operation? Do you know anything about that?

THE WITNESS: No, your Honor.

THE COURT: In other words, for even an individual not on methadone if you exceed these limits it's a danger?

THE WITNESS: Yes.

THE COURT: You would not want to be exposed to it for any period of time at all?

THE WITNESS: That is right.

THE COURT: Do you have any idea of -- well, this is probably an impossible question, but if it can be answered -- for the man on an addict dosage of methadone, would you say that the maximum concentration before danger would be less?

THE WITNESS: Yes.

THE COURT: Are you talking about substantially less or a little less or don't you know?

THE WITNESS: Your Honor, that is the reason why we have not done these studies. First of all, I would like to point out that I tried to find out for my own curiosity the concentrations of these various materials in the atmosphere within the various areas of the Transit Authority and I spoke to the Director of Safety. He doesn't know. The studies have never been carried out as far as he could find out. This was one of the reasons.

THE COURT: You mean on any of these compounds?

THE WITNESS: Yes.

THE COURT: The actual concentration of these substances in the atmosphere, can be found out?

THE WITNESS: Yes.

THE COURT: And you can take certain --

THE WITNESS: Sample of gases and you would analyze the gases for these materials. It's a relatively simple process.

THE COURT: I don't know what any of this means. You don't even know what the concentration in the atmosphere is over there. So what are we supposed to be doing here?

MR. DUNN: Notwithstanding the testimony of the witness on the latter point, I am sure the witness is testifying as accurately as he can. The Director of Safety does in my instances have the concentrations.

THE COURT: He apparently was trying to get it and he might have been able to testify more completely than he is able to testify here today. The record shows to me right now that there is an admission by the Safety Director to him that these things are not known at all, so I don't know what any of this really means.

MR. DUNN: With regard to some. If I may explain, there are some areas where work is done but is open, such as the shop in which your Honor viewed the work going on.

THE COURT: We viewed cleaning operations out in the cold air to some extent.

MR. DUNN: Like the ones out in the yard, not like the ones in the shop. But they are semi-enclosed, and in these areas it is my understanding it has been impossible to accurately measure the concentration because of the drafts that come in, the exhausting of the air, and so on.

THE COURT: I imagine that is right and it probably means that there is not much.

MR. DUNN: Once again I am going to refer to the Director of Safety. They have a problem, I understand, with respect to asphyxiation even in the semi-enclosed or semi-open, whichever way you view it.

THE COURT: What about asphyxiation?

MR. DUNN: There have been problems with individuals being overcome by fumes used in the cleaning of the cars, and to this point I will not address myself as having firsthand knowledge, but Mr. Masocci would be the one. But he did in a conversation tell me that he had contacted Dr. Lync for the purpose of determining whether certain chemicals could be used totally unrelated to this case in certain areas. It was related to me by Mr. Masocci.

THE COURT: Go ahead.

BY MR. BALBER:

Q Dr. Lynch, have you done any studies or were studies done by anyone else on the interaction of acetone and methadone?

A Not to my knowledge.

Q How about the interaction between aromatic mineral spirits and methadone?

A Not to my knowledge.

THE COURT: Do we have to go down this list one by one?

THE WITNESS: May I make a blanket statement, your Honor?

THE COURT: Yes.

THE WITNESS: To my knowledge there have been no studies carried out with any of these compounds in combination with methadone.

Q Dr. Lynch, isn't it true that all of the substances that you have that were singled out by you in your direct examination are toxins?

A In a broad sense, yes.

Q Isn't it true they all cause liver damage in non-methadone maintained patients if they are exposed to them for a period of time?

A Not in all cases.

Q Shall we go through them one by one?

A The exceptions where liver damage would not be caused would be in the case of aromatic mineral spirits, isopropyl alcohol, acetone. I don't know of liver damage with freon 12.

Q Would methylene chloride induce liver damage?

A Yes.

Q Cellosolve?

A No, I would hesitate to say Cellosolve.

Q Cyclohexanol?

A Yes.

Q Isopropyl alcohol?

A No.

Q Dichlorobenzene?

A Yes.

Q Toluene?

A Yes.

Q Commercial Xylene?

A Yes.

Q Dr. Lynch, isn't it true that for that reason a standard practice in industry is to equip employees who work with these with masks?

A No.

Q In your opinion as a pharmacologist should that practice be done?

MR. DUNN: I object to that.

THE COURT: Sustained.

Q Dr. Lynch, isn't it true that there are products on the market that are designed to be worn by workmen to filter these type of substances from the air around them?

A Yes.

Q Dr. Lynch, isn't it true that the commercial labeling on these products commonly state they ought to be used in well-ventilated areas?

A To my knowledge most of the labels do state that.

Q If I were to use, let's say, a paint remover containing methylene chloride in an enclosed atmosphere, would I tend to become dizzy and lightheaded, and I would stipulate that I am not on methadone?

MR. DUNN: We have it so stipulated.

A I would presume depending on the circumstances if there were no ventilation and if the area was small enough, yes.

Q Dr. Lynch, you made some statements earlier about the abuse of alcohol by patients on methadone. What clinical experience do you have to support that conclusion?

A Only the reading of studies that have been carried out.

Q Have you made any firsthand observations?

A No.

Q You stated previously in this case that you did a clinical residency at Northshore Hospital. Did you make any observations there?

A Not on alcohol and methadone.

Q What did you observe there?

A Patients on methadone per se. You have to appreciate that the clinic at Northshore Hospital where methadone is dispensed is not a methadone clinic, it is a detoxification clinic.

Q And the only methadone patients that are referred there are patients with special psychiatric problems?

A Yes, generally speaking.

Q So the methadone patients there are not representative of methadone patients at large?

A You might say that.

MR. BALBER: That concludes my examination.

REDIRECT EXAMINATION

BY MR. DUNN:

Q I would like to read to you two statements that are contained in a package insert for dolophine hydrochloride, and with respect to each statement, Doctor, will you tell me whether you agree with the statement or whether you disagree with the statement or have any comment that you might like to make with respect to the statement. The first is:

> "Interaction with other central-nervous system depressants - methadone should be used with caution and in reduced dosage in patients who are concurrently receiving other narcotic analgesics, general anesthetics, phenothiazines, other tranquilizers, sedative-hypnotics, tricyclic anti-depressants and other C.N.S. depressants (including alcohol). Respiratory depression, hypotension, and profound sedation or coma may

result."

MR. BALBER: Objection. There has been no foundation laid.

THE COURT: Overruled.

Q With respect to that statement, Doctor, do you agree or disagree?

A I agree.

Q The second statement, Doctor, contained in the same package insert:

"Use in Ambulatory Patients - methadone may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks, such as driving a car or operating machinery. The patient should be cautioned accordingly."

Do you agree with that statement or disagree?

A I agree.

THE COURT: Do you have an extra copy of that?

MR. DUNN: Yes.

THE COURT: That is 1973.

MR. DUNN: The first one is the latest one.

THE COURT: And you read from A.

MR. DUNN: It is marked on the copy I gave you.

RECROSS EXAMINATION

BY MR. BALBER:

Q Dr. Lynch, you just made some statements or agreed with some statements about the use of methadone in human beings, but you have never treated a human being medically, have you?

A No.

Q And you have never made any studies on the effect of methadone on human beings?

A Clinical studies, no.

Q And you never treated people on methadone in any kind of an overall program setting, have you?

A No, I have not.

Q So you are simply drawing your conclusions on the basis of textbook analogies?

A No, I would not say textbook analogies. I would say facts that were derived from reference books and also from the literature on the subject.

Q What literature? What studies on methadone patients supports the proposition that methadone patients should not be allowed to use hazardous machinery?

A There is a book -- I am trying to recall the author --it escapes me, but it was published by Thomas Press, and the book is entitled Methadone, published in

Date of Birth: February 24, 1919, Vancouver, Washington

1972. It represents studies, a collection of studies by people, for example, like Dr. Dole and other so-called authorities on methadone, who indicate the central nervous system the present effect of methadone in clinical cases.

Q Does it contain work of Dr. Gordon?

A Yes.

Q And Mary Jean Creek? You don't recall Dr. Creek?

A The name is familiar,but I don't know if this particular book does.

Q It talks about highway safety driving and methadone?

A Yes.

Q And did it contain anything written by Dr. Harold Trigg?

A I don't know if I read Dr. Trigg's work there or elsewhere.

Q But it supports the same proposition?

A On methadone and highway safety? Dr. Trigg has made those assertions.

THE COURT: What assertions?

THE WITNESS: To the effect that methadone-maintained patients have as few accidents as the ordinary, normal driver.

Q But, Dr. Lynch, you just cited that book and Dr. Dole and Dr. Gordon and perhaps Dr. Creek?

A There are conflicting studies in this particular reference.

Q By whom?

A You give me the book and I will show you.

Q Can you name one author in that book who reached a medical conclusion based on scientific evidence that methadone patients should not be allowed to operate hazardous machinery?

A I will not rely on my memory in that regard.

Q Then what are you basing your statement on that you agreed that methadone patients should not drive hazardous machinery?

A Reading that particular book leads me to believe that, yes, a person who is put on methadone will as a matter of fact be less alert than a person who is not on methadone.

Q By reading the work of Dr. Dole, Nyswander, Gordon, Kreek, that is the conclusion you reached?

A By reading a compilation of work like the one I cited, yes.

Q That was the basis for your conclusion just stated?

A Just that particular one.

Q What else have you read?

A Without being disrespectful, I don't carry my files.

Q How many hours did you prepare for this testimony, Dr. Lynch?

A Several.

Q You prepared for several hours. Did you know you were going to be asked about this package insert?

A I had some indication I might be.

Q During that several hours you did not come across any additional studies?

A Yes.

Q So you are basing your statement here solely on that one book; is that correct?

A Not only on that one book, but other information in addition.

Q What other information?

MR. DUNN: Your Honor, I strenuously object to counsel not permitting the witness to answer.

THE COURT: Let the witness answer.

A When I was asked by counsel to consider--

THE COURT: Excuse me. We will have to adjourn briefly now.

(Recess.)

T7 BY MR. BALBER:

Q Dr. Lynch, when we recessed to testify as to why you agreed that methadone should not be used -- well, when we recessed you were testifying about why methadone patients should not operate hazardous machinery, and your basis for that conclusion --

MR. DUNN: Your Honor, may we have the reporter read back the questions and answers?

THE COURT: The reporter who reported that portion is not here. Just do the best you can.

Q Did you also testify during redirect examination that you agreed with the statement in Exhibit C that methadone may produce orthostatic hypotension in ambulatory patients?

A Yes, I do.

Q Tell me, what is orthostatic hypotension?

A That means the blood pressure falls when the individual attains an upright position. Stands up, in other words.

Q Dr. Lynch, have you done any study on persons maintained on a stabilized dose of methadone that would enable you to draw the conclusion that methadone affects hypotension?

A No, I have not.

Q Well, you made some conclusions that you agreed with the statement. What did you base that conclusion on?

A First of all, I have been a pharmacologist engaged in the study of drugs of this nature for a matter of like 15 years.

Q A study of methadone?

A A study of drugs of this type, drugs affecting the central nervous system and the nervous system in general.

THE COURT: You personally?

THE WITNESS: Yes, sir.

MR. DUNN: Your Honor, may counsel be requested to let the witness finish his answer?

THE COURT: Yes.

Go ahead.

A (Continuing) The studies were not all of a laboratory or clinical investigative nature but studies of literature associated with this field; and most of my information, or much of the information that I have about the adverse effects of drugs is gained in precisely that way.

Q Well, Dr. Lynch, what specific literature supports the conclusion that methadone may produce orthostatic hypotension?

A The statement is made here in the package insert which I accept as being authoritative, for one thing --

Q In other words, you said you agree with the package insert because the package insert said what it said?

A Because of the nature of the package insert and how it is developed and what it really means.

Q But, Dr. Lynch, what specific -- other than the package insert itself, what literature that you have examined enables you to conclude that you agree with the package insert?

A I have no specific citation other than the statement made here.

THE COURT: Did you tell us what orthostatic hypotension is?

THE WITNESS: It is a reduction of blood pressure when a person stands upright from a sitting or a lying position.

BY MR. BALBER:

Q Dr. Lynch, can you name one study that you are relying on to support the conclusion that methadone produces orthostatic hypotension?

A No, I can't.

MR. BALBER: Your Honor, it has been a long time since redirect, so I am a little unclear.

Was there any other statement in Exhibit C --

THE COURT: At the top of the page, interaction with other central nervous system depressants.

MR. DUNN: That is not Exhibit C.

THE COURT: Exhibit CCC.

BY MR. BALBER:

Q Dr. Lynch, you agreed with the statement, is it not correct, that methadone should be used with great caution and in reduced dosage in patients who are currently receiving other narcotic analgesics, general anesthetic, phenodiozenes, other tranquilizers, sedatives, hypohypnotics, trisilicate anti-depressants and other C & S depressants, including alcohol. Respiratory depressants, hypotension and profound sedation or coma may result.

Now, Dr. Lynch, what studies have you done that enables you to draw the conclusion that that is an accurate statement?

A Again I have done no personal laboratory or clinical studies. I rely solely on the literature in this particular area.

Q And what specific literature did you rely on when you stated the conclusion that this was an accurate statement?

A In this particular instance you will find this referred to in a number of different textbooks which I considered to be of a reference quality.

Q Textbooks on methadone maintenance?

A On pharmacology.

Q On general pharmacology?

A Yes.

I would refer you to, for example, the fourth and fifth edition of Goodman & Gilman's Pharmacology, to Sallman's Pharmacology in the Eighth Edition -- when was that Eighth Edition published?

MR. DUNN: Has the witness finished the list that he was giving, your Honor?

A (Continuing) The Eighth Edition of Sallman was published around 1958.

Q Are you aware that methadone maintenance as practiced and developed by Dr. Goldenweisbunger was developed in 1965, seven years after that book was published?

A I realize that, but I also realize that methadone was used in medicine and methadone was used in obstretical practice medicine /a but not in chronic high-dose maintenance, is that correct, Doctor?

THE COURT: Just take it easy, Mr. Balber. Just ask the question.

A Not in maintenance, but in detoxification at Lexington, yes.

Q And this Goodman & Gilman volume you referred to, what edition are you referring to?

A Both the Fourth and Fifth Edition.

Q When was the Fourth Edition published?

A The Fourth Edition was 1972 or thereabouts. The Fifth Edition was last year.

Q And what studies on the effect of methadone did this volume cite?

A I am not prepared to give you exact citations.

Q Well, how about some inexact citation; what researchers do this volume mention as supporting the conclusion that methadone had these effects?

A I'm not even prepared to give you inexact citations.

Q Do you remember the names or the titles of any study?

A No, I do not. I simply refer you to the chapter in those two volumes on narcotics and analgesics.

Q Was this chapter on methadone specifically?

A Methadone was considered in that chapter as a narcotic and analgesic.

Q Did this chapter describe methadone maintenance treatment?

A Soman's book would not because it wasn't in effect, and I don't recall if Goodman and Gilman make this citation with regard to methadone maintenance specifically.

Q So that what you base your answer on is Goodman and Gilman--so far as you base it on Goodman and Gilman, you don't even know if Goodman and Gilman were talking about methadone maintenance, do you?

MR. DUNN: Object to that.

THE COURT: Overruled.

A I know they were talking about narcotic analgesic of opiate variety and they specifically mentioned methadone, even though they may not have mentioned methadone in context of maintenance therapy. I am not prepared to state categorically that they did discuss maintenance therapy in that particular chapter.

Q Dr. Lynch, have you received pecuniary compensation for the time spent in preparing your testimony for this case?

A I certainly have.

Q What has the amount of that compensation been?

A I don't know if I have to reveal that.

THE COURT: Oh, yes.

MR. DUNN: We have no objection, your Honor. I have assured the witness that the Authority has no objection.

A So far as my Court appearance is concerned I received $200 and I received $100 for two hours of preparation and consultation.

MR. BALBER: Thank you.

THE COURT: Anything else?

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REDIRECT EXAMINATION

BY MR. DUNN:

Q Dr. Lynch, to what extent do pharmacologists rely upon the package insert?

A The package insert contains all of the known warnings and precautions with respect to medication. It is my knowledge that if I were to accidently discover an adverse effect or a side effect for any drug, it is incumbent upon me to report this on a particular form to Washington. At that time Washington will notify the manufacturer to cease manufacture of that preparation if they feel that the warning is sufficiently dangerous.

The manufacturer has to stop the manufacture and recall, a notice of recall is established. He has to recall the item until such time as he reprints or revises the package insert.

The package insert, in my ignorance I had accepted the package insert as a rather strong document.

Q You are referring to adverse reactions which are not enumerated in a package insert as bringing about recall of product?

A Yes.

MR. DUNN: Thank you.

BY THE COURT:

Q Maybe you covered it before, but what institution are you connected with?

A St. John's University.

Q Are there studies now going on at St. John's or elsewhere as to the effects of methadone? Maybe that is obvious, but what I am trying to get at, are there some important studies now in process that you think might reveal things about methadone not now known?

A You phrase it in a way that is rather embarrassing. The only study that I know of that might contribute in a particular area such as this would be the study we just started. I don't know how important it is.

Q You mean about the interaction?

A Of methadone.

Q Do you know of any other studies now going on about methadone that might substantially increase the body of information about it?

A No.

THE COURT: Thank you very much.

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Address: 100 Haven Avenue, Tower #2, N.Y. 10032 Tel. No. 781-8632

Date of Birth: February 24, 1915, Vancouver, Washington

Education:
B.S., University of Vermont, 1936
M.D., University of Vermont, 1940
M.P.H., Columbia University School of Public Health and Administrative Medicine, 1957

Experience:
1940-1941 Interne, Syracuse General Hospital, Syracuse, N.Y.
1941-1942 Associate Professor, Dept. of Health, Education, University of Southern Illinois, Carbondale, Illinois
1947-1949 Director, Medical Division, Health Education Department, Boston, Y.W.C.A.
1949-1953 Assistant Planned Parenthood Clinic, Mt. Kisco, N.Y. Member Advisory Board, 1949-53
1953-1955 Research Assistant, Dept. of Pediatrics, Columbia University College of Physicians and Surgeons
1956- Columbia University School of Public Health and Administrative Medicine
  1956-59 Trainee and Instructor in Epidemiology
  1959-1970 Assistant Professor of Epidemiology
  1970 to Date Associate Professor of Epidemiology

Research Projects

1. Familial Study of Primary Hypertension with Dr. George Perera, Professor of Medicine, Columbia University College of Physicians and Surgeons, 1959-1965 Project Director

2. Coronary Artery Disease Mortality, 1961-1965 Associate Project Director

3. Survey of Physicians in Washington Heights, 1963-1964 Associate Project Director

4. Survey of Community Health Programs for Epilepsy, 1963-1964 Co-Investigator

5. Evaluation of Methadone Maintenance Treatment Program for Heroin Addiction, 1965-Present, Senior Investigator and Project Director

Professional Certification:
Diplomate National Board of Medical Examiners - current Licensure in New York State - License Number 083424

Membership and Societies:
Fellow, New York Academy of Medicine
Fellow, American Public Health Association
Member New York State Medical Society
Sustaining Member Public Health Association of New York City
Member the Physician's Forum

Revised 12/3/73

Professional Services

1. Executive Secretary, Seminars in Cardiovascular Disease Epidemiology, 1959-1966.
2. Lecturer in Epidemiology, Communicable Disease Center Training Branch, Courses in "Applied Epidemiology" for Nurses, 1962-1966.
3. Associate Director, New York City Department of Health Summer Training Program for Medical Students, 1960-1965.
   Consultant to above program 1966 to 1970.
4. Lecturer and Seminar leader, Course in Epidemiology for Medical Students, New York University College of Medicine, 1966 to date.
5. Consultant to Washington, D.C. Narcotics Treatment Agency, 1970-1972.
6. Consultant to Evaluation Committee San Juan, Puerto Rico Drug Treatment Program, 1970-1972.
7. Consultant to Special Action Office for Drug Abuse Prevention, Washington, D.C., 1972 to date.

Committees

A. Member Public Health Committee, New York County Medical Society 1964 to date.

B. Member of Board of Directors, Public Health Association of New York City, 1963-1972.

C. President, Public Health Association of New York City, 1965-1966.

D. Member of Governing Council, American Public Health Association, 1968-1972. as elected representative from Public Health Association of New York City.

E. Member Advisory Committee to OEO-NIMH developing standard reporting forms for Evaluation of Narcotics Treatment Programs, 1966-1970.

F. Member Advisory Committee of New York State Narcotics Commission on Criteria for Funding of Narcotics Treatment Programs by the Commission, 1967-1972.

G. Treasurer, Physicians Forum, 1971 to date.

Honors and Awards

1. Recipient of Merit Award from Public Health Association of New York City for contribution to the health of the citizens of New York, May 1972.

12/3/73 (Rev.)

Frances R. Gearing

Publications

1. Perera, G. A.; Clark, E.G.; Gearing, F.R.; and Schweitzer, M.D. The Family of Hypertensive Man: Progress Report of a Long-Range Study Program. Am.J.M. Sc. 241:18, 1961.

2. Gearing, F. R.; Clark, E.G.; Perera, G.A.; and Schweitzer, M.D. Hypertension Among Relatives of Hypertensives; Progress Report of a Family Study. Am. J.P.H. 52:2058, December 1962.

3. Schweitzer, M.D.; Clark, E.G.; Gearing, F.R.; and Perera, G.A. Genetic Factors in Primary Hypertension and Coronary Artery Disease. A Reappraisal. J. Chr. Dis. 15:1093, December 1962.

4. Pomrinse, C.S.; de Napoli, R.A.; Schweitzer, M.D.; and Gearing, F.R. Community Health Programs for Epilepsy, Monograph prepared for Neurological and Sensory Disease Service Program, Division of Chronic Diseases, Public Health Service, December 1964.

5. Schweitzer, M.D.; Gearing, F.R.; and Perera, G.A. The Epidemiology of Primary Hypertension. J. Chron.Dis. 18:847, August 1965.

6. Schweitzer, M.D.; Gearing, F.R. Hypertension in The Heart and Circulation. Proceedings Second National Conference on Cardiovascular Diseases, Vol. 1 Research, Eds. Andrus, E.C. and Maxwell, C.H. Federation of American Societies of Experimental Biology, Washington, D.C. 1965.

7. Bergner, L.; Garon, L.P.; Gearing, F.R.; Schweitzer, M.D. Coronary Artery Disease in Private Practice. A Survey of Physicians in a District of New York City. Amer. J.P.H. 56: 638, April 1966.

8. Schweitzer, M.D.; Gearing, F. R. Hypertension in Chronic Diseases and Public Health, Eds. Lilienfeld, A.M. and Gifford, A.J. The Johns Hopkins Press, Baltimore, 1966.

9. Schweitzer, M.D.; Gearing, F.R.; and Perera, G.A. Family Studies of Primary Hypertension: Their Contribution to the Understanding of Genetic Factors in The Epidemiology of Hypertension. Eds. Stamler, J., Stamler, R., and Pullman, T.N. Grunne and Stratton, New York 1967.

10. Gearing, Frances R., Progress Report of Evaluation of Methadone Maintenance Treatment Program. In: Proceedings of the First National Conference on Methadone Treatment. The Rockefeller University, 1968.

11. Gearing, Frances R., Evaluation of Methadone Maintenance Treatment Program. Int. J. Addictions, 5, pp 517-543, September 1970.

12. Gearing, Frances R., Evaluation of Methadone Maintenance Treatment Program. In: Methadone Maintenance. Einstein, S., Ed., Marcel Dekker, Inc. New York, 1971.

13. Gearing, Frances R., Successes and Failures in Methadone Maintenance Treatment of Heroin Addiction in New York City. In: Proceedings Third National Conference on Methadone Treatment. NIMH, Bethesda, Md., 1971.

2/22/72

Frances R. Gearing

14. Gearing, Frances R., Proceedings Fourth National Conference on Methadone Treatment. San Francisco, 1972. A Road Back from Heroin Addiction, Page 157.

15. Gearing, Frances R., Proceedings Fourth National Conference on Methadone Treatment. San Francisco, 1972. People versus Urines, Page 325.

16. Gearing, Frances R., Proceedings Fourth National Conference on Methadone Treatment. San Francisco, 1972. Deaths Before, During and After Methadone Maintenance Treatment in New York City, Page 493.

17. Gearing, Frances R., Contemporary Drug Problems Vol. 1:2, Spring 1972. Methadone Maintenance - Six Years Later.

18. Perera, George; Gearing, Frances Rowe and Schweitzer, Morton D. A Family Study of Primary Hypertension - Final Report. J. Chr. Dis. 20:3, March 1972, pp. 127-132.

19. Gearing, Frances R., Proceedings Fifth National Conference on Methadone Treatment. Washington, D.C., 1973. Myth versus Fact in Long Term Methadone Maintenance Treatment: The Community's Viewpoint.

20. Gearing, Frances R., Treatment of Opiate Abuse by Methadone Treatment. In: Psychopharmacological Agents, Volume III. M. Gordon, ed. Academic Press, New York, 1973.

12/3/73 (Rev.)

riesa

CARL A. BEAZER, et. al,

Plaintiffs

-against- 72 Civ. 5307

NEW YORK CITY TRANSIT AUTHORITY,

Defendants.

October 30, 1974
10:30 a.m.

- - -

* * *

FRANCES ROWE GEARING, called as a witness in behalf of the plaintiffs, after having been duly sworn, testified as follows:

DIRECT EXAMINATION

BY MR. BALBER:

MR. DUNN: Your Honor, may we request of counsel for the plaintiff to be provided with a copy of Dr. Gearing's report. They had provided us with a copy and we offered that as an exhibit which was marked as a plaintiffs' exhibit.

THE COURT: I have two on the bench here.

THE WITNESS: I'm sorry I didn't bring any reprints.

THE COURT: That is all right.

MR. DUNN: May we have one, your Honor?

THE COURT: I am trying to find it.

MR. BALBER: Here is an extra copy.

MR. DUNN: Thank you.

Q Dr. Gearing, is this a copy of your curriculum vitae?

A Yes.

THE COURT: Has that been marked?

MR. BALBER: Please mark this for identification.

[Plaintiffs' Exhibit 46 marked for

identification.]

MR. BALBER: There is no objection and I request that it be received so that there be no excessive testimony.

MR. DUNN: No objection.

THE COURT: Received.

[Plaintiffs' Exhibit 46 received in evidence.]

Q Dr. Gearing, are you familiar with this study?

A It is in a much prettier form now. It has a blue cover. Yes, I am.

Q Do you adopt it as your direct testimony in this case?

A Yes.

MR. BALBER: Your Honor, I would like to move the admission of this study previously marked.

THE COURT: It is already admitted. It was offered by the defendants.

MR. BALBER: Your Honor, I will try not to be unduly repetitive of what is in the report. I will touch on a few highlights.

THE COURT: Okay.

Q Dr. Gearing, in your statement it is stated that you monitored the performances of some thirty some odd thousand people who enrolled in methadone maintenance treatment in New York City. Is that correct?

A That is correct.

Q How did you receive data pertaining to these people?

A In a variety of ways. The first data comes from the Rockefeller Data Bank which gives us basic data on their admissions and their date of birth, and then we get data from the programs that have periodic -- the periods of time. We get data from all the publications and we do sampling in which we collect the data on our own by talking to the patients individually.

Q What kind of data do you get?

A Primarily -- we are primarily interested in data which has to do with the social rehabilitation of the patients in the methadone treatment because that is the goal of the program, which is to make the patients more socially productive.

Q Do you get data regarding continued drug abuse by persons in programs?

A Yes.

Q Do you get data regarding alcohol abuse by people in programs?

A Yes.

Q Do you get data regarding employment of people in programs?

A Yes.

Q Do you get data regarding the arrest records of persons in programs?

A Yes.

Q Do you get data regarding educational activities by persons in programs?

A Yes, both training programs and graduate educational programs.

Q And do you make an attempt to follow specific persons over time?

A That is our whole goal. Our initial charge was the long-term effects of methadone maintenance treatment, so we have followed the initial cohort which was submitted between 1964 and 1968. We followed that cohort now for over five years and we have followed each successive cohort by sampling. The first cohort is 100% sampling.

Q This first cohort that you mentioned, when were they admitted to methadone maintenance treatment?

A Between 1964 and 1968.

THE COURT: Can I just be clear on exactly who you are working for that does these monitoring activities?

THE WITNESS: It is the Columbia School of Public Health, Division of Epidemiology. It is funded by the State Narcotics Addiction Service, now changed to the State Drug Abuse Control Commission and as of November 1 will be funded by --

THE COURT: It is on Page 2, thank you.

THE WITNESS: Yes.

THE COURT: Go ahead.

Q You mentioned an initial cohort that you are following. By cohort you just mean group; is that correct?

A That is right.

Q And you followed these people since what year?

A Well, the initial six were admitted in 1964. This would be others of the 1,245, or whatever the figure is, that were admitted between 1965, when the program actually started, through 1968, and the reason for choosing that date was that they had two things in common.

One was that all of these patients were started on their stabilization dosage as in-patients.

Q So the shortest period of time anybody had been in this group is six years?

A That's right.

Q And the longest period of time is?

A Ten years.

Q Dr. Gearing, what has your data revealed regarding the correlation of drug abuse in length of time and treatment?

MR. DUNN: Objection, your Honor, the foundation has not been laid for the witness to give expert testimony.

MR. BALBER: Your Honor --

THE COURT: Well, look, I have gone through this statement quickly and I certainly haven't gone into it in any depth. Is this something that's in the statement?

MR. BALBER: Yes, your Honor. Well, it's in the statement --

THE COURT: Just to save time now. When you're referring to something in the statement, why don't you help us all out by pointing out the page.

MR. BALBER: Your Honor, perhaps we can give you some help.

THE WITNESS: I have a different pagination.

MR. BALBER: The first cohort of patients is described, the group of persons you're referring to is described on page 3, I take it under Topic A.

THE COURT: You better have the same pagination we've got.

THE WITNESS: That's all right, I'm well familiar with the material.

THE COURT: You will be referring to pages in our copies, all right.

THE WITNESS: Yes. Page 3, that just defines a cohort, yes.

THE COURT: What's the next one?

Q What I'm interested in getting at, Doctor, is in sort of common sense terms, the longer these people stay in treatment, are they more likely to abuse drugs?

A The proportion of those using, continuing to abuse drugs or alcohol diminishes as they stay in the program. It has probably its peak in the first -- in the first and second year. And then levels off.

Q And levels off at what level in this cohort?

A Never more than seven percent and with drug abuse roughly around 10 percent with alcohol.

THE COURT: Is that specifically in your study, those figures? Will you point those out to me?

THE WITNESS: I'm not sure it is in there. It's in the other paper that I gave to -- let's see.

THE COURT: Drug abuse and alcoholic use, the chance of that diminishes as the treatment continues, right?

THE WITNESS: Yes, sir.

THE COURT: And what -- the peak you say is in the first and second years?

THE WITNESS: Yes.

THE COURT: And what kind of statistics do you have about such drug abuse and alcohol usage?

Are there any things specifically in this report at all? If it is in there, I'd like it pointed out.

THE WITNESS: I'm not sure this report dwells on that. We dwelled primarily on the social productivity in this report. I do have some data on drug abuse which - -

MR. BALBER: I believe on page 21 there is a general summary but not in a very specific form. It's in the second complete paragraph on that page.

THE WITNESS: Yes, but that's referring to cohorts entering the program having a different pattern than the initial cohort. That's a little bit different question.

THE COURT: Let me just take a look.

THE WITNESS: As I understood you to ask me the question, it referred to the first cohort of patients whether or not their pattern of alcohol and drug abuse had increased in the time they had been in the program. The answer to that is no.

Q Asking you about people who have been in treatment the longest.

THE COURT: Okay. Go ahead.

Q How is data about continued drug abuse gathered? What's the data basis?

A Data basis is the periodic urine sampling plus the counselor's reports where they are attempting to help the patient to deal with the problem. The urine reports are used in this program as a guide to the fact that the patient needs some help.

Q So your data then is based on urine reports over a period of six to ten years depending on the individual patient?

A Yes.

Q Doctor, do you also gather information about the dosage level the patients are maintained at?

A We started to, and then we found that it was really pretty unnecessary because the stabilizing dose in the bulk of the patients in the methadone treatments that we are monitoring are stabilized at a dosage somewhere between 80 and 120 milligrams, at least for the first year or so.

At that point decisions are made either with the patient in consultation with the doctor about whether or not they are ready to try detoxification and so we now have a cohort of patients who have started down on the detoxification route, some of them are now "drug-free," many of them have stabilized at a lower dosage.

Q Doctor, did the data that you have gathered indicate that dosage tended to increase with time and treatment? I'm talking now after the initial six weeks or so of treatment?

A The regime, and this regime started long before the federal guidelines came out, was that they start on a broken dosage of 10 milligrams, morning and night, that's 20 milligrams, and then gradually work it up to the point where they are on 80 to 120 milligrams per day in one dosage.

And some of the patients, as I mentioned, have been maintained at that level for six to ten years.

THE COURT: Now, you start -- they started at about 10 milligrams?

THE WITNESS: 20 milligrams a day, but in divided doses.

THE COURT: Twice a day, 10 milligrams, twice a day?

THE WITNESS: The programs vary a little, some of them do it all in one dose, but it's roughly --

THE COURT: ANd they work up over what period of time?

THE WITNESS: Roughly six weeks.

THE COURT: To 80 to 120 milligrams. So if something is selected as the stable dose somewhere between 80 to 120.

THE WITNESS: This was based on the work that Dr. Dole did with the initial six patients at Rockefeller University. Those six patients still being in the program. His decision was at that level the patient is -- is what he terms a blocking dose for rather high dosages for heroin.

In other words, they get no euphoria if they shoot.

THE COURT: The question is very simple. Some dose is selected.

TEH WITNESS: That's correct.

THE COURT: And then the person is kept on that dose?

THE WITNESS: Unless he requests to have it reduced?

THE COURT: But it's not increased.

THE WITNESS: That's correct, it is not increased.

THE COURT: Now, he will be kept on that dose for how long before -- well, you said that he might be kept on that dose until the time comes that they give some consideration to doing something else?

THE WITNESS: There are, I guess, three main reasons. One, the patient decides that he wants to try it without methadone. The doctor thinks that he has completed his social rehabilitation to the point where he might try it. The combination. Then they start on a very slow detoxification schedule, because the problem with detoxification for methadone is that it is a longer acting drug than heroin, therefore it takes longer to detoxify somebody.

THE COURT: So if there is an agreement between the patient and the doctor to try detoxification, they do it?

THE WITNESS: That's right. Some patients go one step further and they demand it. They want to go free. And they are also detoxified but a little more rapidly.

THE COURT: Now, generally, what period of time does the detoxification take?

THE WITNESS: It varies entirely with the patient. The notion of detoxification from the methadone maintenance is, we will keep the patient as comfortable as we can. In other words, they don't want to get him to the point where he has discomfort which could be called "withdrawal symptoms." And if he gets to a point where he is taking -- we have one patient that's taking two and a half milligrams in the morning and two and a half milligrams at night in order to keep himself comfortable. That's what could be called by any doctor's standards placebo dose. Medically not very active, but on the other hand, it's a point at which he is comfortable and that's the rule, the criteria, and the same thing is true is the patients go all the way down to where they are drug-free, if they ask to be built up again, that they have that freedom of choice. It's an open door policy.

THE COURT: Go ahead.

BY MR. BALBER:

Q Now, after a patient is leveled off, if we can step back in your testimony - -

A STabilized.

Q Stabilized and leveled off at a constant dose, does any data from the group, the 37,000 patient group you monitor, indicate that with time drug abuse in the leveled-off person tends to increase?

A We have no data to support that.

Q What does your data indicate?

A Our data would indicate just the opposite. Now, there is a group of patients out of that who had obviously multiple addictions when they came in. Some of them it interferes with their rehabilitation to the point where they are transferred to other kinds of programs, because methadone maintenance is not a treatment for poly-drug abuse.

Q What proportion of the patients is this with drug abuse problems?

A That are withdrawn from the program? Probably two or three.

Q And what percentage of the patients that remain in the program continue to abuse drugs?

A After six years, practically none. I don't say they are completely drug-free, but you're using the word "abuse," which means continued use.

Right?

Q All right. How many show sporadic abuse?

A Well, that's a difficult question to answer because there is no feeling in the methadone maintenance treatment philosophy that there is something bad about occasionally taking a drug or occasionally taking a drink. The abstinence syndrome is not part of it. The question is, if they are abusing drugs or alcohol or doing other things which interfere with their social rehabilitation, and that is, their ability to get and remain employed, then it becomes a problem.

Q Okay.

What percent remain abstinent if we were to apply that standard?

A Remain abstinent?

Q Yes, except for methadone, of course?

A I don't know as I -- well, my arithmetic would have to go down. I would guess more than fifty percent. I have no problems with either. Ever.

Q With either drugs or alcohol?

A Yes. It's probably higher than that.

MR. BALBER: Your Honor, because of the length and depth of Dr. Gearing's written statement, I have nothing further. I have a few more questions.

MR. DUNN: What did counsel say?

THE COURT: He has some other questions not related to the written statement.

Q Dr. Gearing, how many patients are in the Beth Israel methadone maintenance treatment program?

A As of December 31, 7,170.

Q And this is based on the Rockefeller data bank?

A Yes.

Q The computer count?

A It's called Beth Israel and affiliates, yes.

Q How many patients are there in the New York City methadone maintenance treatment program administered by the Health Services Administration?

A My figure is 12,380.

Q And how many patients are there in the Bronx State Methadone Maintenance Program?

A 2,400.

Excuse me, plus an additional 265 at Van Etten which include the TB patients, that's also Bronx.

THE COURT: The total number of methadone patients at Bronx State is what?

THE WITNESS: 2,665, of which 265 are patients who have active TBs as well as heroin addiction and a slight overload of alcoholism. Van Etten is a part of the Albert Einstein Medical Center.

Q What proportion of the total methadone maintenance population is enrolled in one of these three programs?

A What proportion? Well, you will have to do the arithmetic for me.

Q Roughly.

A As of December 31st, I have 40,585. That's the total of which 14,050 are in private clinics. The rest are under our supervision.

THE COURT: This is as of December?

THE WITNESS: 31, 1973.

THE COURT: You have got a total in New York City?

THE WITNESS: 26,535 out of a total of 40,585.

THE COURT: You're going a little too fast for me. You have to the total in New York City is what?

THE WITNESS: 40,000 -- well, that includes a few in Nassau.

Nassau and Suffolk Counties and Westchester County. I don't have that broken down.

THE COURT: In other words, this is total in New York, Nassau and Westchester?

THE WITNESS: In the greater New York area. 40,585.

THE COURT: Please, just a second. This is the total in New York City, Westchester County and Nassau?

THE WITNESS: Right.

THE COURT: Now, what's that number?

THE WITNESS: 40,585.

THE COURT: And of those how many are in the --

THE WITNESS: 26,535 are under our supervision.

Private clinics. We do not have supervision over them. Not supervision, monitoring, whatever you call it.

THE COURT: You're monitoring. Now, the clinics you monitor or the programs you monitor are Beth Israel, right?

THE WITNESS: Beth Israel, Bronx State, Van Etten, Health Services Administration, Westchester County and a group of voluntary hospitals which we have listed as affiliates, include Roosevelt, Mount Sinai, Bellevue -- Bellevue is not a voluntary hospital -- there are a few others, and those are all publicly funded by the State Drug Abuse Control Commission as our funding comes from them.

THE COURT: So that all the programs at Beth Israel the City Health Services, Bronx State, including that Van Etten?

THE WITNESS: Right.

THE COURT: This Westchester group you spoke of and this group of hospitals gets public funds?

THE WITNESS: That's right.

THE COURT: And they treat -- they were treating 26,500 people as of --

THE WITNESS: December 31st.

THE COURT: Now, how much public funds is poured into this?

THE WITNESS: That is the part of the monitoring that I have nothing to do with. I see figures like several million dollars being given to Beth Israel Medical Center and several million dollars being given to HSA. The total figures, I don't know. I can tell you how much we get but it doesn't come in the millions.

THE COURT: That would leave about 14,000 patients in private --

THE WITNESS: That's right.

THE COURT: --perhaps. How many such private programs are there?

THE WITNESS: Well, as of December 31st, I could count 76 separate treatment units that were listed private, five of which were in Suffolk and Nassau, the rest are in the borough of Manhattan -- New York. Oh, excuse me, it's 43. I add something that shouldn't be added. 43 different treatment units.

THE COURT: The private units, treating 14,000?

THE WITNESS: Yes.

THE COURT: And how many in Suffolk and Nassau?

THE WITNESS: Five.

THE COURT: And 38 in New York City?

THE WITNESS: Right.

THE COURT: And you don't do any monitoring on those?

THE WITNESS: The only thing we do is administrations and discharges and transfers becuase what happens is we get into the publicly funded program, patients who have transferred out of private, originally admitted to private clinics and transferred in, I have a feeling, when their money runs out. Most of these private clinics have started up within the last -- since late '72, '73 and now '74, when the State provided that Medicaid funds could be used to pay for drug abuse treatment.

THE COURT: So you can go to a private clinic and get Medicaid for whatever period of time the Medicaid covers and then when the money runs out they try to get over into one of these funded institutions?

THE WITNESS: Yes, and apparently with the expansion of the facilities, then the drop in the waiting list, this is what is happening, and that is, there is a good deal of transfer from the private clinics.

THE COURT: But you do not monitor the other programs in the sense of getting information about progress and drug abuse and so forth?

THE WITNESS: We have no right of entry into any of their data.

THE COURT: Okay, anything else?

MR. BALBER: Yes.

BY MR. BALBER:

Q Dr. Gearing, what are the three largest programs in New York City?

A The largest program at the moment is the Health Services Administration.

Q That's New York City?

A That's the youngest of the programs, but it was the most rapidly expanding because it had a charge to cut the waiting list out.

The Beth Israel is the oldest one and is the second largest, and the third largest would be Bronx State and its affiliates.

Q Now, together, what proportion of the publicly funded program population is in these three programs?

A Of the publicly funded?

Q Do they have the majority?

A Oh, yes, far and away. There are only 3,000 in theother publicly funded.

Q So there are --

MR. DUNN: Your Honor, may I have --

MR. BALBER: I am trying to make a comparison among programs and I think it would be more useful than calling each program head.

MR. DUNN: May I have the record note the witness is referring to documents in the course of her testimony.

THE COURT: Okay, fine. Let's go.

A I'm referring to a progress report which I did give in. It's just that I can't keep the numbers in my head.

THE COURT: Okay. Let's proceed.

Q Now, do you receive drug abuse reports on people participating in the Beth Israel program?

A YEs.

Q And New York City program?

A Yes.

THE COURT: This is repetitious.

Q How does the New York City program population compar in terms of continued drug abuse with Beth Israel?

A Beth Israel has a slightly better record but part of that is that they were slightly more selective of their patients. The Health Services Administration program started with the open door policy, the loosening of the criteria for admission, and the attempt to cut down the waiting list, and so they do have a larger group of patients in with multiple drug problems and alcohol problems.

Q So it is slightly worse?

A Slightly worse.

Q How does the Bronx State program compare with Beth Israel?

A Bronx State is so similar that it is almost a carbon copy, except that they have a much higher proportion of Puerto Rican and Spanish patients and a slightly less in the blacks, but their retention rates and their employment rates and so on and so forth are very similar.

Q Now, your study contains social productivity measures which we won't describe here in the study. How do these three programs compare in terms of the social productivity of people in these programs.

A Very similar.

The problem with the social productivity is that as the program expanded the problem of obtaining meaningful employment for the patients as they became employable became more and more of a problem due to a variety of factors, one being the general job picture in New York City, the feeling on the part of many employers that they had to maintain some kind of a quota system, we'll take a few --

Q Doctor, it is very useful, but to save the Court's time, I want to get the overall picture of how these programs compare, and I believe you said they compare -- I don't want to put words in your mouth. They were similar.

A Very similar. The difference in the various cohorts have to do with the time of entry into the program and the situation at the time they entered.

Q Are you aware of the supportive services provided by these programs in terms of counselors on premises, physicians, vocational, rehabilitation, and the like?

A Since all of these programs were built on what is known as the Dole-Nyswander model an attempt is made in each of these programs to have very similar supportive services.

The rapid expansion of the Health Services Administration made it a little difficult for them to keep up for a while in hiring the personnel demands some of their rapidly expanding facilities, but I think that's been handled.

Q You made an attempt -- well, strike that.

How do these three programs compare with anti-social behavior, arrest records and conviction records of the persons participating in those programs?

A Once again, I don't think that I can do that kind of comparison between the programs because they are quite similar, what has happened is that the new cohorts coming in have a different pattern, and that is that their experience in the first two years is that a higher proportion of them have poly-drug abuse problems and their rate of getting arrested is higher.

But that's a cohot phenomena, not a program phenomena.

MR. BALBER: Your Honor, that concludes our direct.

* * *

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Vincent P. Dole, M.D.

Birth: May 8, 1913 - Chicago, Ill.

Citizen: U.S.A.

Education: Stanford, California - A.B. Mathematics; 1932-1934
Harvard Medical School - M.D.; 1937-1939

Research and/or Professional Experience:

1941 to present - Rockefeller University. Professor & Senior Physician to the Hospital.

Diplomate, American Board of Internal Medicine

At present, activities include: Research on methadone maintenance treatment for narcotic addiction; Member, Board of Trustees, Alcoholics Anonymous

Elections:

Fellow of the American Academy of Arts and Sciences, Boston, Mass., May 1969.

Member of the Institute of Medicine, May 1971.

Member of the National Academy of Sciences, April 1972.

Awards:

1969 - Public Health Association's Haven Emerson Award for outstanding contribution to public health through the development of the Methadone Maintenance Program for the treatment and control of drug addiction.

1970 - Modern Medicine Award for Distinguished Achievement in recognition of concerned attention to the problem of narcotic abuse and scientific & clinical work with methadone treatment of addiction.

1970 - Lakey Award in recognition of outstanding contribution to the establishment of narcotic rehabilitation programs through the use of methadone.

1970 - Gairdner Foundation International Award in recognition of pioneer contributions to understanding of the metabolism of free fatty acid and adipose tissue, and more recently for the significant work in establishing a valuable method of treating narcotic addiction with methadone.

1972 - Stouffer Prize, awarded for original work on the isolation of free fatty acids from plasma, and demonstration of their origin in body fat stores and interrelationships with insulin and carbohydrate metabolism.

1974 - William Hammond Award for Distinguished Service.

1974 - James D. Bruce Memorial Award for distinguished contributions in preventive medicine.

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UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

- x

CARL A. BEAZER, et al., :
Plaintiffs, :
v. : 72 Civ. 5307
NEW YORK CITY TRANSIT AUTHORITY, :
Defendants. :

- x

Before:

HON. THOMAS P. GRIESA,
District Judge

January 7, 1975
2:00 p.m.

APPEARANCES:

ERIC D. BALBER, Esq.,
MARK C. MORRILL, Esq.,
ELIZABETH B. DuBOIS,
Attorneys for Plaintiffs

JOHN G.deROOS, Esq.,
Attorney for New York City Transit Authority
EDWARD W. SUMMERS, Esq.,
GILBERT T. DUNN, Esq.,
of Counsel.

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THE COURT: We are resuming the trial of this action to hear certain experts pursuant to an order which I signed last week.

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VINCENT DOLE, called as a witness by the Plaintiff, being first duly sworn testified as follows:

MR. BALBER: Your Honor, I previously requested a copy of Dr. Dole's curriculum vitae which might be useful to the Court.

Will it be received as a Court exhibit or a plaintiff's exhibit? I'm not sure of the mechanics. We have no objection to it being a plaintiff's exhibit.

MR. DUNN: May we have a copy of that, your Honor?

THE COURT: Let's not waste time.

xx (Plaintiff's Exhibit 48 received in evidence.)

MR. DUNN: Your Honor, may I request that counsel move the stand back further so there is a possibility of our hearing.

DIRECT EXAMINATION

BY MR. BALBER:

Q Dr. Dole, your vitae states that since 1941 you have been a professor and senior physician at Rockefeller University.

Can you describe briefly in what fields you have done research?

A I make a minor correction. I became a professor in 1952 but I have been there on the staff since 1941. It was not until 1952 that I became promoted.

Apart from that I have been continuously in research since the period 1941 in the field of metabolic diseases, chemistry of the body and physiological disturbances of kidney functions, liver functions, neurological functions.

Q What year did you first become involved in research regarding heroin addiction?

A In 1963.

Q Can you describe briefly how you became so involved?

A Yes. I became interested in the problem because I so so much addiction around me in New York City, and as a consequence, I spoke to people in the Health Department who were my friends and I found myself in 1963 appointed to be chairman of the Health Department's Health Research Committee on Narcotics, and so in that capacity, I became fairly rapidly educated, visited all the facilities, met all the principal people in the field of narcotics, went to Lexington, for instance, and made as much of a study as I could at that time.

THE COURT: Lexington is the federal--

THE WITNESS: Treatment Center at Lexington, Kentucky, yes.

THE COURT: All right.

A Later in 1963 I decided to throw the main resources of my laboratory into the study of narcotics addiction and so with a grant from the City Health Department's Health

Research Council, I undertook the research.

Q What did your first experiments in this area involve?

A I was struck with the thought that much was in the medical literature about the acute limited effects of narcotics given in single doses to people or to animals, but very little was known about the long-term effects of known amounts of narcotics given under medical supervision for research purposes.

So our first experiment was to admit hard core relapsing heroin addicts to my metabolic ward at Rockefeller University Hospital and study their state of function, their physiological reactions with known doses of different narcotics that were known in the pharmacopoeia,not exotic drugs.

Q Which narcotics did you use?

A Morphine, heroin, metnadone, oxycodone, and--

Q Demerol?

A And Demerol, yes.

So we have studied under controlled conditions the response of established addicts to various doses of narcotics.

Q What did you observe when you administered heroin to your experimental group of patients?

A Very much the same reaction as the administration of morphine since heroin is turned into morphine in the body. In both cases, you have a drug that must be injected if it is to be effective in any moderate-size dose and the period of action of these short-acting injectible drugs is only an hour or two depending, of course, on the dose.

At the end of, say, two hours, the addict is now again sick, needing drug, looking at the clock, waiting for the next injection.

We found that the dose of the drug needed to maintain any sort of cooperation of our patients in this experiment would go up and up so that I became persuaded that any attempt to stabilize an addict on repeated doses of an injectible drug like morphine or heroin or, for that matter, these other short-acting drugs, Demerol and the like, was not likely to be a practical success.

Q What did you observe when methadone was administered to your patients?

A To our surprise, because this was really not anticipated as you might with hindsight, we found an entirely different reaction. Methadone, for one thing, is effective by mouth so that slows down its point of action.

Secondly, methadone is stabilized in the body so that the blood level of methadone is quite constant even when a single dose is given per day.

The result was that our patients were maintained in a state that seemed to be entirely normal in every respect. We were so surprised to find these very same addicts that had acted just as typical hard core addicts on morphine and heroin, to find them apparently lose interest in drugs while they were on methadone part of the experiment and begin to talk about getting jobs or going back to school or just having ordinary conversation about political, sport topics and the like.

Q How many persons were involved in this initial methadone experiment?

A Six people during the first five months of our intensive study.

Q Did you later expand your experimentation?

A Oh, yes. As the experiment proceeded and it seemed to us that we had now potentially at hand a key to this very complicated problem of rehabilitation, I spoke to Dr. Ray Trussell, who was Commissioner of Hospitals of New York City, showed him our results.

He looked, and with very little hesitation, picked up the phone, called Beth Israel Medical Center and told them that he wanted to send a doctor over, and he was asking them to give me a ward to do a demonstration study and that he would take care of the administrative side.

He said, "just let's get this experiment done."

THE COURT: Can I ask you when you are talking about methadone, I was not clear about the-- just go over that again. Methadone, you said, since it went into the mouth, was slower-acting.

What else?

THE WITNESS: It also is distributed into the body issues in such a way that the body tissue acts as a sort of stabilizing buffer for the blood level.

Q Can you explain what a buffer is, Doctor?

A The nervous system responds to the concentration of a drug that is brought to it in the bloodstream and so if now one wants to have a stable condition for the nervous system, you can translate the problem into the questions of whether the concentration of drug in the bloodstream is held at a steady level.

The question then is, what are the factors that would operate to give a stable blood level. One factor would be that when the drug is taken by mouth, it is absorbed into the bloodstream only over a period of time rather than sent into the bloodstream in a pulse the way an injected drug is done.

Secondly, when the drug is absorbed into the blood, it very quickly leaves the blood and is taken up by tissues in general: muscle tissues, fat tissues, lung tissues, and this tends to hold the blood level more or less constant and as the drug is removed, then the tissues supply drug back into the blood to hold a level so steady--

THE COURT: When you say blood level, you mean the concentration of the drug in the blood?

THE WITNESS: Yes, sir.

THE COURT: And you are saying with methadone, this is a mechanism for keeping it more or less stable for a longer period of time?

THE WITNESS: Yes, sir. I think that that may be the key to the unique success of methadone compared to other narcotics in attempts at maintenance.

THE COURT: Do you know why this would lead to less of a narcotic effect? You said these people would talk about normal things and so forth.

Does that have to do with the stability?

THE WITNESS: Yes. That's my theory. The nervous system will develop a tolerance to narcotic drugs when the nervous system is exposed to them.

Now, if the concentration of narcotic in the bloodstream going into the nervous system is constantly changing, the nervous system is confronted with excesses of drugs and then deficiency so it never achieves a perfectly stable condition of tolerance.

When you have the drug delivered in such a way the concentration is almost constant for 24 hours, day after day, the nervous system becomes so accommodated and so tolerant that it ceases to react to that drug as a narcotic any more.

THE COURT: Okay.

You were talking about getting a ward at Beth Israel.

MR. BALBER: Yes, your Honor.

pm

Q To what degree was your experiment expanded in that ward?

A Our first group of admission was 12 and by the end of this year, which we are now into the year of 1965, I think we have gone to something to the magnitude of 200 or so but it initially was so dramatic in its success that we were urged on all sides to expand as rapidly as we could and at that point Dr. Trigg who had been and still was, the head of the detoxification service that existed in the hospital, became very interested and we recruited him to join in our work, so he was actually one of the first two assistants to my wife and myself in starting the expansion of the program.

Q I don't think the record indicates yet, Doctor, could you please give your wife's name?

A My wife is Dr. Marie Nyswander.

Q And she has been your collaborator?

A She has been the collaborator from the very beginning of our research work and continues to do research with me.

Q During this chemical experimentation that you described, did there come a time when you developed a rehabilitation program involving maintenance on methadone?

A Oh, yes.

Q Can you describe about when that was?

A Really very near the beginning because although the first objective of our research at Rockefeller University was simply to explore the physiology of narcotics given chronic dosages, once we began to see this really dramatic effect of methadone and extinguishing the hunger and the seeking for narcotics, it clearly opened the door to what we all were looking for, namely, some after of genuine treatment because both my wife and I have felt from the beginning that the real problem with narcotics addiction is to enable a person to live a normal life. There has been perhaps an over-emphasis on the drug side. The real problem is the human being involved with this. So we had people willing to talk about things other than drugs and we began to explore the question of whether they might want to pick up school again, so we set up contacts for some of them to go to night school and all of our patients got high school equivalency diplomas while they were in this experiment.

In addition, four of the patients managed to have part-time jobs outside and we arranged they could leave the hospital when we weren't doing some special test and hold part-time jobs; so we had moved as rapidly as we could to rehabilitation from the onset.

Then as we got to Beth Israel, the demonstration program, the central feature of our effort was rehabilitation. The pharmacology part had really been proven. The question now was could we put this to work in order to enable people to have a normal life.

Q Can you describe more specifically what the components of your rehabilitation program were?

A Yes. The first component in any rehabilitation program is to give a man a sense of self-respect, belief in himself, dignity, hope, it is realistic.

Q What do you do in a program to assist him in that?

A One of the first things you do is to respect him. For one thing, I wuld never let anybody and still don't let anybody call my patients addicts. They are patients and if you were my patient, you would be Mr. Balber, you wouldn't be Joey or whatever. You start respecting people to enable them to respect themselves.

Secondly, as time went on, we began to recruit people that had an understanding and a sympathy and a general feeling for people to help in real ways because the next step is, if somebody is disadvantaged, he is black, he has had no education, he has been washed out by addition from early adolescence, he has been five times in jail, he has no family. You are dealing with a man that is a social casualty. He has had so many disadvantages it is overwhelming and the problem of the drugs is really a small part of the issue. So, in any good rehabilitation program, you must look with some understanding at the real problems that a person suffers, not some theoretical problem whether he has immature attitudes and so on but the question is what are the real impediments to this man achievieng a decent place in the world, so what we have done over a time is to find support, work with all the local agencies and groups that contribute,job finding, educational agencies. We would see to it that we could get welfare support for people that are indigent so we could at least get them a decent footing to move from.

We would work as vigorously as we could to get them to get jobs so they can get off welfare and have self-respect for their own dispute. We would look into their family problems and see what we could do to reconstitute and if anybody has an addicted spouse, we would see to it that the spouse got treatment and so forth.

I thi-nk that rehabilitation is not just some formula thatyou rubber-stamp onto a person. It is a matter of really caring for what is problems are, then using every effort you have to try to bring some remedy.

Q You have described your rehabilitation program which involves the administration of methadone,then the other types of supports and counselling you just mentioned. Are there methadone maintenance treatment programs in operation in New York City today of which you have knowledge that incorporate your rehabilitation program?

A Oh, yes. To a considerable degree, every methoadone program in the city is derivative upon the model that Dr. Nyswander and myself developed at Beth Israel and in fact the directors of the program, the major programs trains with us and helped us develop the programs. Dr. Trigg, we have mentioned, is now head of the program at Beth Israel Medical Center and Dr. Joyce Lowinson is newly graduated from her psychiatric residency and came to work with us at Beth Israel, now heads the Bronx State program.

Q You mentioned Beth Israel.

Do you know how many people are in that program that Dr. Trigg directs? There has been prior testimony it is about 6500.

A I don't remember the exact figure but that certainly is a reasonable guess.

Q How about in Dr. Lowinson's program?

A I think about 2500. Maybe between 2500 and

3000.

MR. DUNN: We didn't hear the name.

THE WITNESS: Dr. Joyce Lowinson.

Q Which program is that?

A At the Bronx State Hospital associated with Einstein Medical School.

MR. BALBER: It has been previously mentioned only as to the extent as mentioned in Dr. Gearing's testimony and I believe the testimony showed she said the social characteristics were almost identical with the Beth Israel situation.

THE WITNESS: I could also add that Dr. Newman who just this past month retired as director of the New York City Health Department Program --

Q How large is that program?

A That is about 10,500 or 11,000 patients.

THE COURT: That is the New York what?

THE WITNESS: New York City Health Department Methadone Maintenance Program.

Q That is a municipal program?

A Yes. These programs, I should say, are not located in just one clinic or just one spot. They represent a disbursed network of clinics administered with a central authority.

Q Have you been associated with Dr. Newman as well?

A Yes.

Dr. Newman was actually brought into the field because of his friendship and our solicitation of his activities. He was in the field of public health as a district health officer prior to our recruiting him for this job.

THE COURT: You say he recently resigned?

THE WITNESS: Yes. He currently is in Hong Kong because the Hong Kong authorities feeling the growth of an addiction problem there made a survey through the United States and they felt he was the best person equipped to set up a methadone treatment program so they have set up for him to come over for three months to set up and administer and train the personnel for a large scale program there.

THE COURT: Do the Bronx State and the City Health Department programs have rehabilitation services?

THE WITNESS: Yes, sir.

Q Are you aware of other treatment programs that are built on the model of your rehabilitation program?

A Yes. I would say that all the methadone programs in New York City in various degrees adopt this model. They all certainly accept the phisosophy that the primary job is rehabilitation and all of them now provide a structure of rehabilitation services. They have counselors, they have vocational assistants, midical supervision, and of course an affiliation with other types of agencies that provide supplementary services. They all accept the same philosophy.

Q Dr. Dole, in what ways have you maintained contacts with these programs that enable you to draw these conclusions?

A The main process is my methadone data center at Rockefeller University.

When we first began our research on methadone, I was struct by the absence of reliable and systematic data in the field of addiction; thatall these different agencies made large claims and conflicing opinions and I didn't find any data in the field. As an old research fellow I set about to develop a data system which has stayed with the field and grown to the present time and as of now, we operate a computerized data system that registers every patient receiving methadone in a recommended methadone treatment program in the metropolitan New York area. That embraces not only the five boroughs but also Nassau, Suffolk, Westchester and some adjacent areas.

Q Rockland County as well?

A Not yet. We have approximately 40,000 actual patients in our files. In the course of maintaining the census information, obviously I learned about the importance of the clinics in some degree. I am aware of how well they are able to retrain their patients and from an additional source of information, I have a fairly good index of the failures of the clinics as may be reflected in arrest statistics.

Q Let's get into that a little. In addition to just numbers and pure census figures, do you also have social data, drug abuse data and the like?

A Yes. On not all the programs but on the public, the public registered programs, public registered program, we have monthly reports sent to us which describe the problems, if any, the clinic has experienced with a patient, the employment, the housing, the family status and the legal status and this information which is almost uniquely comprehensive in any field of medicine is made available to the independent evaluation committee so they have a factual basis to judge.

Q Who is the chairman of that committee?

A That is Dr. Gearing's committee at Columbia.

Q Is she monitored by an overseer or group of overseers?

A She has a committee to which she is answerable. She is the executive of the committee but the committee is composed of an assortment of professionals in the field of public health who are independent of any methadone program.

Q Dr. Dole, based on your experience and information from this data bank, have you formed opinions as to the overall effectiveness of methadone maintenance treatment programs in the metropolitan area?

A Oh, yes. The effectiveness has to be defined in two parts. One is the limited measure effectiveness which is to stop drug abuve which of course is the first step of a program.

The wider measure of effectivess is whether the patients will stay with a program and realize something of their potential such as going back to school, getting a job or a woman making a home and having a stable family and by these objective indices, I would say that methadone is very effective indeed.

THE COURT: Is what?

THE WITNESS: It is very effective.

THE COURT: By both standards?

THE WITNESS: Yes, sir. I would say if you take the measure of terminating illicit drug abuse, the actual numerical score would vary of course from clinic to clinic depending upon what kinds of patients are being treated.

When you deal with people just out of the Tombs or are you dealing with a more privileged middle class group of addicts, but I would expect a good clinic to have at least 90 per cent success in terminating all illicit drug abuse during the first six to twelve months and thereafter drug abuve should become even less and less of a problem.

No medical treatment is 100 per cent successful. There are difficult patients with whom we fail.

Q Doctor, are there means available to employers of which you are aware by which they can assess the quality of particular methadone maintenance treatment programs?

A Yes.

I think in the first place they could look to the overall regulatory control of all methadone programs so they know what they are dealing with.

Methadone programs today are obliged to meet very rigorous standards of support therapy and supervision that are laid down by the federal government and by the State Narcotics Commission.

Q When were the state standards promulgated?

A I don't think I could answer it exactly.

THE COURT: What was the question?

MR. BALBER: I was asking when the state standards were promulgated?

THE COURT: There are of course federal regulations and there are state regulations, right?

THE WITNESS: the state regulations to a large extent merely reformulate the federal regulations, so I don't think it is an independent phenomenon.

The federal government after the FDA formulated regulation, attempted to transfer supervisory relation to the states and I think it would be more useful to bracket themtogether because it is the same collection of rules.

3pm

Q Are the state standards more rigorous than the federal standards?

A Yes. If anything, the state adds on its own rigor, but we go back to your question as to what could a prospective employer rely on and if I put myself in the position of a prospective employer, I think myfirst reliance would have to be on the fact that these are very carefully supervised treatment programs and so, therefore, it is unlikely that you will have a great irregularity from one program to another.

THE COURT: What are the problems requiring supervision?

THE WITNESS: Frankly, I think the mainproblem is public relations. There is so much community reaction and prejudice that people are constantly saying: We must supervise and supervise.

The other part of it, which is a great concern, is it is possible in the absence of regulation for unscrupulous doctors to make a fortune out of something like this.

The need is enormous and it happened in years past that some doctors would just prescribe methadone with no controls, with really no reason except just to make money for selling the medicine.

THE COURT: And there is a certain amount of public money going into this?

THE WITNESS: Yes, sir.

THE COURT: You may, without controls -- the controls being on what, the type of person who should get methadone?

THE WITNESS: Yes, sir.

I think that firstly, as you say, the patient must be diagnozed and identified as a person needing the treatment.

THE COURT: I know that it probably is in the record but just refresh my memory. In general, the criterion for somebody becoming a patient is what?

THE WITNESS: That theperson have at least two years of continuous unremitting and unsuccessfully treated heroin addiction, that he be motivated to want treatment and sufficiently cooperative to follow the rules of the clinic. The age limits have been set as of the present time at the lower age 18, except in special research programs.

THE COURT: What I am trying to get a handle on, maybe it is obvious, the dangers if you just-- let's take the worst situation. You have somebody who has no -- well, he is just willing to corrupt this thing in whatever way it can be corrupted; what would happen? He would use it as a means of selling methadone simply for addicted narcotic users?

THE WITNESS: There was a fear in the early days of this program that somehow or other distributing a legal narcotic to people who may need it would somehow lead to a diversion of channel that would now flood the neighborhoods with narcotic and thereby create a whole new generation of addicts.

THE COURT: In other words, you and the programs who have-- well, the programs you have described are genuinely directed at treatment, right?

THE WITNESS: Very much,yes, sir.

THE COURT: And naturally, they are not directed at just supporting somebody's habit in some wother way, right?

THE WITNESS: That's right.

THE COURT: And that's one reason for controls.

What kind of controls makes sure that you are not just selling to somebody who wants a drug and doesn't care about being treated?

THE WITNESS: I may, if I could, back up and correct a little bit.

THE COURT: All right.

THE WITNESS: It is in practice very difficult to know what a person's motives are at any one time. By and large, if a person is an addict from the street, his problem is just to keep alive and he is desperate.

My job as a therapist, as a doctor, is to try to move him to a position where he has motivation and self-respect and opportunity so I can't expect him to have all these positive motivations at time zero, so to some extent it is a moving process.

As to the matter of controls, the real fear that generated many of these controls, as it turns out, is no longer justified, but the controls persist. There was a fear, which it turns out to be unsupported now, that people would become addicted to methadone in the first instance. If it were available, the children in school would become addicted to it. The people in the neighborhoods that never used narcotic drugs would become addicted to it.

The remarkable fact is that this medicine, as we give it by mouth, is so poor in any sort of use for euphoric or play-with-drugs sense that it has not generated any new addicts to speak of.

This is almost negligible.

If one looks for new addicts that have been created by methadone, they are virtually impossible to find.

Q Doctor, aren't there persons on the street, people not in programs, who did use methadone?

A Yes. Now we come to a problem.

Q Who are they?

A They are people who have used heroin and became addicted to heroin and who are unwilling now to come into treatment programs because they would rather get the heroin on the street-- I mean get the methadone on the street and stop using heroin.

In a sense, the black market methadone has become a safety valve so that when the supply of heroin is dried up, there is less desperation in the streets.

THE COURT: Let me see. You are saying there is a black market in methadone?

THE WITNESS: Definitely, yes, sir.

THE COURT: And former heroin addicts will use it as a kind of substitute?

THE WITNESS: In order essentially to get away from heroin. Yousee, the general image that heroin is a lot of fun is a definitely mistaken impression. Most heroin addicts, after help, are really hooked, are trapped into a desperate game. There is far more misery than fun in it and they are usually running for the drug, stealing, selling what they have to, getting the money merely to get relief from the sickness that he is left with after.

THE COURT: Why would they return to methadone?

THE WITNESS: Just for relief.

THE COURT: Why would they not want to come to a clinic?

THE WITNESS: One of the main reasons is that the regulations that are imposed on the clinic have become so onerous now that there are many addicts that would rather just take their chances and buy it in the black market and treat themselves.

THE COURT: You mean there are demands put on the patients in the clinic?

THE WITNESS: Yes, sir.

THE COURT: That some people won't --

THE WITNESS: Yes, sir.

THE COURT: For instance --

THE WITNESS: For instance, a man must come to the clinic every single day, six days a week for at least three months regardless of whether he is employed or decent or responsible or whatever. Arbitrarily.

THE COURT: Is that a federal regulation?

THE WITNESS: Yes, sir. And it's been reinforced by the state. Even if a man is completely rehabilitated, has a steady job, has a reputation in his community, has a family and all the commitments that a man should have in society, and he will have perhaps had four or five years of background of successful experience, and if this man is still judged by me as his doctor to be benefited by some sort of continual,sustaining,moderate dose just to keep extinguished any narcotics, according to federal and state regulations, he must come back twice a week to the clinic for --

THE COURT: As long as he is on the program?

THE WITNESS: Yes, sir. There has been, in effect, a pressure from the law, the federal regulations, from public opinion to get people off the program.

It is this type of a pressure--

THE COURT: Are there other demands, aside from the attendance that these people don't want to comply with sometimes? Is there a requirement that they participate in some rehabilitation program?

THE WITNESS: It varies from program to program. The ones I would recommend, the demand on a man for let's say psychotherapy or for any other type of group activity would be related to his state of rehabilitation.

There are some clinics that would require a person to come into group therapy forever, not so much in New York, I am happy to say, but in other cities in the country, on the theory so long as he needs methadone, he ought to come twice a week to a group therapy.

These attitudes are driving people out of programs and deterring people from coming into programs.

There is a more subtle pressure, too, exerted, as you will see, from television programs, from newspaper accounts, from public opinion in various ways that in some way or another people condemn patients for being on a methadone program.

They say: If they really amounted to something, they would leave the program.

Now, that, I think, is a terribly destructive attitude because in my view the pharmacological aspect of this should be regarded as much a medical issue as the pharmacological treatment of some metabolic disease like gout or diabetes or cardiac disease.

I think it should be a medical decision as to what medicine makes for the best function for a person.

Here I am in the position of having to fight public opinion for the right to exercise my medical judgment. These things are conspiring to drive people out of programs and it is making it very hard even to open up a new clinic to treat a person.

Q Dr. Dole, are you still engaged in research regarding the pharmacology and chemical aspects of methadone?

A Yes. I have been involved in that from the beginning and continue to do so very actively.

Q So you have been involved in it continuously since 1962, was it?

A 1963. Actually in 1964 is when I started research. 1963 I became first involved in the program via committee work.

Q This is laboratory research?

A Laboratory work. I have a colony of mice that I am studying that are addicted. We have a great number of studies of human subjects in the type of experiments where you can measure the concentration of methadone in the blood and the distribution of methadone in the body and the exretion of methadone and the metabolism, as to how narcotics are changed in the body and so forth.

Q Are other persons associated with you in this research?

A Yes. Dr. Kreek has been associated with me for the ten years of our work. I had assigned to her the responsibility to coordinate the medical studies of the medical safety or medical problems so she has conducted very systematic, careful, continuing studies of the patient's organic function.

Then associated with me also, Dr. Norman Gordon, an experimental psychologist. We brought him from Yeshiva University with a background of examining people for neuromotor function and vigilant skills and so on, and he has been associated with me for, now, for some eight years, and also has a laboratory in my department.

Q To what extent has your research revealed that methadone has adverse physiological consequences?

A We have not discovered any major adverse conditions in ten years of careful examination.

Q As long as a person is maintained?

A Yes. Now, I'm speaking, of course, of people that are properly stabilized on methadone and are receiving the medication under competent medical supervision.

THE COURT: Read the last answer, please.

(Record read.)

THE COURT: What could happen if they were not?

THE WITNESS: The worst possible situation--

THE COURT: Let me explain the reason for my question. You have been good enough to come down here and I think this was explained to you before.

We want to assure you that you are not becoming a one-sided participant in a lawsuit.

You are really testifying at my request so I can be sure I've got the deepest insights I can get.

From my standpoint I am trying to inquire about this. In the first place, I want to assure you that I don't think anybody in this room really questions the bona fides of this as a treatment thing. That isn't really our inquiry.

Our inquiry is to see whether there is a constituional obligation on the part of the Transit Authority to depart from their policy,in their judgment as they have arrived at it,and be required to hire in some degree methadone patients.

What I am trying to consider is this.

Normally when we are talking about a constituional problem, like the problem of the black, the problem of equal rights for females versus males, we are dealing with a basic human being.

When we get into the methadone situation, as it is presented to me, we are dealing with a basic human being plus a program.

If you just had the basic human being out on the street taking methadone as he wished, nobody in this room has suggested that there is any constitutional obligation to employ him-- that hasn't even come up. The whole emphasis has been on the human being plus the program.

Now, that really leads me to my inquiry. If the program goes wrong in some way, and I don't know how it could exactly, what would happen-- and maybe the best way to approach it, if you would be good enough to answer this unpleasant question:

In what ways can a program go wrong or could a program go wrong, and this doesn't require you to identify programs that go wrong, but just answer me in a hypothetical sense.

Can you do that?

THE WITNESS: Maybe it would be useful to try to answer it in the wider context of medical treatment.

THE COURT: All right.

THE WITNESS: One might ask the question as to whether there would be a constitutional responsibility to hire a diabetic, and my feeling is that if a diabetic is under good medical care with a stabilized routine of insulin and diet and good medical supervision, then obviously he is capable of handling at least most normal jobs and it would be unfair to deny him a chance of employment on the grounds he is just a diabetic, period.

One could say in what way could a diabetic clinic go wrong?

Obviously, if he ceased to attend the clinic or if he did not take the medication as prescribed, then his diabetes could go out of control.

If he had medical complications and he were so neglected that the clinic did not inow about them and he had disabilities that the clinic couldn't recognize, the clinic would have failed.

I would say in the context of just general medical treatment.

THE COURT: Let's take it with methadone.

For instance, your answer was that you have not discovered any major adverse physiological effects and you said you were speaking of people who were receiving their dosage and they were receiving it under the competent supervision.

Now, what if that wasn't occurring? They would be either not getting their dosage or they wold be getting too much or what would be happening?

THE WITNESS: It is possible, it is very possible that nothing bad would happen so it doesn't invariably follow, but the most undesirable thing would be that a person would ,say, stop taking his methadone and would go back to heroin and then get involved in criminal activity become, say, heavily alcoholic, and have all the problems that alcoholism has.

THE COURT: What about if he got-- let's suppose bad judgment -- I am posing what may be an extreme thing. I have to do it to illustrate. Is there a problem at the other end of the spectrum where he gets too much?

THE WITNESS: No, sir. Oddly, that seems not to be a problem. The reason is that methadone generates tolerance which means that the body ceases to react to it as a narcotic and when a person is tolerant to a stabilized dose of methadone, one could double or even triple that dose and this man would show no effect or very little effect.

THE COURT: Well, are you saying that the-- we have had references in other testimony to methadone as a strong drug, a strong narcotic, something like that. It has never been very clear to me what that means.

What is-- if I just approach it as a layman, if somebody told me they were taking a strong drug, I would have visions of some tremendous effect on the nerves or something that did something very undesirable to the man, created delusions, created tremendous nervousness or something. That's what I would picture when somebody tells me something is a strong durg.

Are you telling me that there really is no adverse effect from methadone in the sense we normally understand the effects of drugs in the way I have been talking about?

THE WITNESS: If I could take a moment to just define the pharmacological concept of tolerance.

THE COURT: Okay.

THE WITNESS: If you take a narcotic drug and administer a given dose to somebody who has never had a narcotic drug at all before, it will cause a set of symptoms, of which the most prominent is drowsiness. It may cause nausea and vomiting and may actually put a person completely to sleep, depending -- and it may suppress breathing.

That's the complexion of narcotic effects of a person completely naive to drug receiving a moderate sized dose.

If you were to give that same dose again to that same person and give it again and again and again, within a rather short time, let's say, within a week or so, that person would cease to have those effects at all.

That's called tolerance. It means that the body by mechanisms that are not yet understood but surely are biochemical, has acquired a resistance against that specific drug whereby it ceases to react to that dose.

If you increase the dose some more, you may get back some of those reactions but you go at that higher dose for a period of time and once more the body has built up its tolerance to the point where the body no longer reacts to the drug.

Step-by-step one could increase the dose of methadone and extinguish reaction to the drug at that dose. Over a period of, say, three or four weeks, one can gradually build up the tolerance in the subject to the point where a truly huge dose, 100 milligrams, would give no effect whatever.

The body of this person now is so tolerant to this medication that it could take a dose that could be even a lethal dose for a normal person and have no effect.

THE COURT: Let's suppose, even, suppose some extreme situation. A fellow goes to a clinic and in some bizarre way, when he is fairly new, they give him a dose that he has not developed this tolerance for; what -- is this going to produce drowsiness in him?

THE WITNESS: Yes, sir.

THE COURT: It is a dose he is not ready for; what will be the effect?

THE WITNESS: It will probably make him drowsy or if it is too much for that, it will put him sound asleep.

THE COURT: Could it kill him?

THE WITNESS: Yes.

THE COURT: We have to take a short recess.

THE COURT: Is it not possible to have abuse of methadone? Maybe that isn't a good term. but going back to the testimony before recess, you said if somebody took a dosage of methadone that was more than they should have, they could have this effect of drowsiness?

THE WITNESS: Yes,sir.

THE COURT: Would that be the only effect?

THE WITNESS No, sir. If the dose were quite excessive, it would so depress the breathing center that respiration would become less and less adequate and the means by which a person not tolerant to methadone could be killed by methadone as to have such a huge dose that it knocked out breathing.

THE COURT: In the case of heroin, is there not some pleasurable effect which people get that causes some craving for heroin?

THE WITNESS: Yes, sir.

THE COURT: Is it called euphoria?

THE WITNESS: Yes, sir.

THE COURT: Do people who take methadone get any of that?

THE WITNESS: No, sir. Certainly not when they are stabilized on a program.

THE COURT: Again, our hypothetical instance is somebody taking methadone that he or she should not be getting. Would he get this euphoria or pleasurable sensation that people get from heroin?

THE WITNESS: In some degree, yes, sir, he could, and I should add we have been talking about methadone as being taken by mouth, which is the form in which it is administered in programs and the like.

If methadone is obtained in a form suitable for intravenous injection, then it has many of the properties that heroin has and it could be abused by an addict and on self-administration could get euphoria, so it clearly belongs to the same family of drugs.

THE COURT: That is helpful.

In other words, there is a distinction in the clinical usage but it can on the black market be turned into some form so it could be administered intravenously?

THE WITNESS: We have gone to some pains to prevent that because methadone is dispensed in the clinics diluted up into a relatively large volume of syrup or it is dispensed in tablets that have had a colloid binder built into it in such a way that it must be dissolved in a large quantity of solution to be soluble and these devices make it unavailable for intravenus injection. So, a person obtaining methadone say diverted from a clinic or from a pharmacy, would have to be something of a chemist to go through a process of extraction and purification to bring it out in a form suitable for injection.

THE COURT: Mr. Balber.

Q Doctor, you testified about research on physiology. Are you aware of any research that has been done from the psychomotor performance and cognitive abilities of persons maintained on methadone?

A Yes, we have done it in our own department extensively. Dr. Norman Gordon --

THE COURT: I don't mean to interrupt you but I am aware of Dr. Gordon'a material and just to save this witness' time, I don't need to have that repeated.

Q Is there any literature in the field on that subject in addition to Dr. Gordon's?

A Yes. The normal functional state of people in treatment programs has been commented on in virtually all the articles that have been reported from different clinics around the country.

Q Dr. Dole, have you had the opportunity to examine a transcript of testimony that was tiven in this case by Dr. Vincent Lynch?

A Yes, I have.

Q How did you obtain that transcript?

A I had it from you.

Q Does that look like the transcript I sent you?

A It is another copy of the same transcript.

MR. BALBER: Your Honor, I would like to refer to the transcript. You have another copy for the Court's convenience.

Q Dr. Dole, on page 759, beginning on line 14 Dr. Lynch characterized methadone. He said, "Your Honor, methadone belongs to a class, a pharmacological class of compounds that will generate tolerance in an individual. Tolerance means specifically that more and more of the drug has to be taken into the system to satisfy biologic needs."

At first I have one specific question: Is Dr. Lynch using the word "tolerance" as it is accepted in standard pharmacological works?

A No. I think he shows a confusion here between the concept of tolerance and the concept of physical dependence.

THE COURT: Concept of what?

THE WITNESS: Physical dependence in technical terms.

Q What is the true story on methadone?

A The definition, if I may, the definition of tolerance accepted by pharmacologists is simply a resistance to the action of a drug or an agent so that a given dose produces less effect or no effect in the tolerant subject as compared to the non-tolerant subject. The concept of tolerance in accepted pharmacological language has no relation to the question of biological needs.

Q No relation to addicts per se?

A No, not at all.

It is obvious if a person is an addict and takes repeated doses of drugs, he will become tolerant, but to equate tolerance with addiction and particularly to equite tolerance with drug seeking behavior and biological needs is strictly in the sense of pharmacological terms, a confusion.

MR. BALBER: There is some further testimony where Dr. Lynch uses the terms.

THE COURT: If you substituted the phrase "physical dependence" for the word "tolerance" would his statement be accurate?

THE WITNESS: Still note quite accurate, your Honor, because physical dependence would require that the patient take a certain amount of drug to meet this abnormal need to find physical dependence, but it does not imply that the need will increase.

For instance, if you have a person on a methadone program. He has in the pharmacological sense, physical dependence. The definition there is if you stop the drug suddenly, he will show signs of withdrawal and that is the specification of physical dependence. There is no inherent reason why a person or animal on physical dependence will need more of the drug, so I will say that the person speaking in this has done two things that are in error in a strict pharmacological sense.

One is, he has misused the word tolerance and, two, he has imputed an increasing need for a greater dose which is not inherent in the concept of either tolerance or physical dependence.

Q If you will turn to page 773, pursuing this a little further, Doctor. Beginning on line 5.

THE COURT: What page?

MR. BALBER: 773, your Honor, beginning line 5.

Q There is a question by the Court -- no, it isn't. "Dr. Lynch, before we broke for lunch, you were discussing the tolerance that develops through a narcotic and you were discussing specifically the tolerance as it develops in a person participating in a methadone maintenance treatment program.

"Was it your statement that the person on the methadone maintenance treatment program develops increasing tolerance to methadone?

"A I don't recall what my statement was, you know, exactly, but what I should have said,if anything, is that the person develops continuing tolerance. That the tolerance level does increase as the time goes on.

"Q Does it follow, Doctor, that the person then must take increasing doses of a narcotic to maintain the same level?

"A I would say in a majority of cases, yes, that eventually yes, this is going to have to have to happen."

Does that indeed happen in methadone maintenance treatment, Dr. Dole?

A No, I would say it is certainly wrong for a vast majority of cases.

Q What research or data do you have to support that?

A We have the experience now that has involved these more than 40,000 people who have received methadone treatment and,of course, it is my monitoring this program through the data center and otherwise through direct contacts that I know that once a person is brought up to the stabilizing fixed dose, he then can be continued on that fixed dose for an indefinite period of time without any craving or need or demand to increase it further. Indeed, the general practice in the programs at the present time is to reduce the dose after the first or second year because a person has become much further away from any prospect of lapsing into heroin and there really is not a need for that high a blockade dose and to reduce the dose to down to what may have been half the level of what he has received in previous years is no problem at all.

Q Dr. Lynch said that he had an experimental basis for his conclusions too. That appears on page 787 beginning on line 8. There was inquiry about what the basis was for his theory and the answer was:

"Our limitation insofar as the experimentation is concerned is based upon a number of considerations, one of which is kind of ethical. Consequently we have not established any models, established any human models for studies of this nature. We have established animal models and we have found that our animal subjects demonstrate the conditions analogous to withdrawal when we try to maintain on a static dosage over a period of time, so we have to increase the dose in order to alleviate."

You testified earlier that you have done studies pertaining to narcotics in animals as well as humans. How predictive of human behavior vis-a-vis methadone or other narcotics is methadone vis-a-vis animal behavior?

A In this area it is a poor uncertain predictive value. One variable, for example, is that an animal to be maintained in any state of addiction must be given a dose of 10 to 25 times as much as the human stabilized person would take so you are working at an entirely different dosage level.

Secondly, where one comes to the question of abstinence in animals, it is very difficult to detect abstinence and to study it. They, of course, lack the capacity to complain the way humans do so you learn nothing about this sensation of anxiety or dysphoria and you have to rely upon such data as weight loss or diarrhea or some sort of abnormal reactions in their behavior and these are not really very sensitive, so I would think it would be a very doubtful strapolation for a person who has had any sort of experiments with animals to consider himself qualified to say what is going to happen with patients. I would find it incredible to try to develop policy that would govern the management of persons on such limited information.

5pm

Q Doctor, can you define in simple laymen's terms what a doctor means when he says that one drug potentiates the action of another?

A Yes. It is a term that is used in different ways.

I would say that there are essentially two different kinds of usages. One usage has to do with simply adding up effects. What would probably be a good example of that would be a combination of aspirin and codeine to relieve pain.

The mechanism by which aspirin relieves the pain is to interrupt certain nerve impulses from the outside and the mechanism by which codeine alleviates pain is to dampen out the central nervous system reaction to pain so here you have two separate mechanisms, both of which are adding up to diminish pain in a useful way, so that's potentiation.

Another sort of potentiation is much more direct; namely, if Drug A is removed or destroyed in the body and Drug B knocks out the removal mechanisms, then Drug A will be potentiated because it stays around the body for a longer time.

Q On page 787, continuing on line 18:

"Q There are human beings that have been given standard dosages for many months or years, have there not?

"A Yes.

"Q What happens to those people?

"A Apparently these are the people who are developing other drug problems. The current concept appears, the current idea appears to be that many of these people are turning to alcohol. They are becoming alcoholics. Alcohol is a substitute or reinforcement or potentiating agent so far as methadone is concerned."

A I would say that's wrong and unfair and I would be curious to know the evidence under which he would base a statement of that sort.

Obviously alcohol and alcoholism is a common condition and if a person were to go in any neighborhood, particularly a ghetto neighborhood, and just make a survey of the incidence of alcoholism, you would find a high incidence of the problem.

We are dealing to a large extent in our programs with people who come from disadvantaged situations so our clinics are having to deal with a combination of problems and we certainly do not want to turn our backs on people because their problems are so complicated, but for this witness to claim that people have become alcoholics because of methadone is in my judgment a very unfair statement and one that, so far as I am aware, is not supported by facts.

Q Have you observed patients of yours who are on maintenance dosages who are engaged in what we commonly call social drinking?

A Oh, yes. In fact, obviously the majority of patients conform to the social norms of their cultural groups and problems with alcohol are the exception, just as they are within their own peer groups.

Q When witnessing these patients engaged in social drinking, have you witnessed any physical manifestations that would lead you, as a doctor, to believe that the action of the methadone was being potentiated by the alcohol contained in the drink?

A No, I have not. I have had many occasions to witness the basis of social conditions because we have been to many celebrations and weddings and whatnot and I would say that the behavior there is certainly within the norm of the cultural group.

Q Doctor, can you explain pharmacologically why alcohol does not potentiate the action of methadone?

A Well, because the sites of action are clearly different. They belong to different pharmacological classes and the tolerance generated to narcotics by methadone maintenance provides no tolerance against alcohol.

The tolerance to alcohol in a drinker provides no antecedent tolerance to narcotics, there are no cross-effects that would put them in the same family.

And so far as any studies have gone, alcohol has no effect on the blood concentration of methadone, upon the metabolism of methadone or upon the rate of excretion of methadone.

Q Turning to a somewhat different topic, Doctor, Dr. Lynch testified, in part he mentioned studies on some earlier experimentation you had done with Dr. Nyswander and there was some discussion about your work and your favorable experimental results.

Starting on page 764, line 21:

"Now Dr. Dole and Dr. Nyswander both will admit--"

"THE COURT: Dr. Dole is the Rockefeller Institute Doctor?

"THE WITNESS: Yes.

"THE COURT: And Dr. Nyswander?

"THE WITNESS: His colleague, his wife.

"THE COURT: Colleague and what?

"THE WITNESS: The methadone program that they initiated back in 1965-1966. They both admit that, for example, when they selected the patients into their methadone maintenance programs they were selected. They eliminated what they call the psychopathological personality, and this was the individual whom they felt they would have poor success with, the person who had a peculiar type of motivational syndrome that might have been biochemical in origin."

Q Doctor, is that a correct characterization of your experimental protocol?

A No. In fact, I have great difficulty trying to understand what he is saying here. Maybe the best thing to do is for me to say what we did do.

Q Do you understand-- did you use what they called the psychopathological personality; did you call people that?

A No. I don't think we ever used that word and it is the ambiguity of that expression is partly why I am so confused on what this witness is trying to say.

Q Do you know what a motivational syndrome, biochemical in origin is?

A I don't know. At the time we started our research we had no special theories at all. We simply wanted to study addicts that were taking heroin and so far as possible, were not addicted to any other drug, so we could study one pure problem.

This question of all these motivational syndromes certainly were not in my mind and I don't know what he is trying to say here.

Q Were there any people with particular kinds of personalities that you were checking?

A Yes. If a person was frankly psychotic so as to be effectively out of touch with any --

Q Like a schizophrenic?

A Yes. We did not want to get into the complication of treating that disease when we were studying heroin addiction but so far as the people having different personality, or antisocial personalities, the fact is we deliberately chose the people that were the most troubled individuals because we were doing research and we wanted to see whether in fact we had any remedy.

Q What was the average--

THE COURT: I didn't hear that.

THE WITNESS: We chose people with a record of addiction and social disturbances, people who had been in jail for five or more times. People who had failed treatment programs before. People who had showed no response to other approaches of any kind.

So we deliberately sought out the worst to see if we had any new remedies to come into this.

Q What was the average period of addiction, if you can remember, of your initial patients?

A I would have to refresh my memory but it certainly was more than five years and as a guess, it was eight or more years.

Q Doctor, on page 767, Dr. Lynch talked further about his analysis of some reasons for some statistical distortion in analyses of your work and he says on line 21, in part:

"The other reasons were that in the initial studies all of the patients were prison inmates."

Doctor, did any of your experiments involve prison inmates?

A No. I don't know how the witness had this impression because the truth is exactly the opposite. None of our initial patients were prison imates and as a matter of fact, we were very careful to avoid even taking into our initial study people who were under any sort of judicial constraint, because we wanted to study the effect of the treatment itself and not the effect of some sort of compulsion from the outside.

Q Doctor, on page 751, Dr. Lynch described some of the side effects of methadone.

Beginning on line 19:

"The central effects are rather difficult to explain. The effects on the brain; the drug undoubtedly occupies receptor sites and it disrupts the effect or neurons transmitting impulses in the brain.

"Now, some of these, some of the neurons are involved in the cerebral cortex and that would affect cognitive faculties.

"The ability to respond voluntarily in certain situations."

Q Doctor, has your physiological research or that of your colleagues indicated that there is any disruption of the cognitive faculties when a person is maintained on methadone?

A No. On the contrary, we have much data by now that the cognitive and other emotional and intellectual faculties of the mind are normal. We have done the type of tests that you already probably had reported through Dr. Gordon's laboratory on specific things such as IQ measurements and various other perceptual tasks.

What probably is more important to this point is now a very large record with some tens of thousands of patients who have gone to school and had high grades, who have accomplished much in responsible jobs, in business and elsewhere.

A properly stabilized methadone patient performs at an entirely normal level by all measures of cognitive ability.

Q On page 755, Doctor, beginning on line 18, the middle of line 18:

"While a methadone addict is under treatment with methadone, he is taking a drug which is classified as a central nervous system depressant.

"In my experience it is a central nervous system depressant.

"I would say that regardless of the fact that the person has been on methadone for any period of time, he still will display some degree of inhibition of these cnetral functions."

A It strikes me as a rather vague statement. I don't know what the witness is claiming here but I will say by objective testing that all the tests that I have seen or inferred from the performance of patients show that the patients are performing at normal levels, so I would think that it would be necessary for him to be more specific in what he is claiming here.

Q Doctor, to what extent are you familiar with the literature in the field of methadone maintenance?

A I think I am almost totally familiar with it.

I certainly kept abreast of it the best I could and I maintain a file in my department on everything that seems to be relevant to the subject.

Q Page 785, Doctor, and this goes, I think, in part to a question the Court was asking previously.

Line 12, the middle of the question:

"Let's take that first instance where he has come into the clinic. Is he going to get any euphoric effect from the methadone?

"A I am not trying to equivocate but in some cases and in some cases no. In cases where he gets a degree of euphoric effect, he will probably continue with the program. When he finds that he does, that all of his needs are not satisfied, is liable to be the one who is going to drop out of the program."

A Not true.

Q And what do you have to support that?

A The clinical experience that we have had over these ten years have shown just the reverse. Many patients have come into treatment on the mistaken theory that they were going to get a free ride and a free euphoria for a long time and have very soon found from their own experience and talking to other patients that they do not get euphoria.

It is perfectly possible that somebody will be disappointed and drop out at that point if he has been frustrated but it is the job of the program to give him some other meaning in his life and in the great majority of the cases, that's achieved.

It certainly is not true that only the people who get euphoria stay because people don't get the euphoria.

THE COURT: You say that you have patients who come in thinking they will get euphoria. They find they don't and they get somewhat disappointed and you are saying it is the job of the clinic to handle that problem if it arises, right?

THE WITNESS: Yes, sir.

THE COURT: How did you handle that problem?

THE WITNESS: You appeal to the pride and hopes of a person because a man doesn't come in just for euphoria and certainly nowadays that methadone is well-understood by addicts on the street, nobody really believes it. This is something in the early days when we were doing our program and the rumor got out,"here were some doctors who were handing out narcotics, let's get into it."

Some of our early patients came in with this false impression that they were going to get euphoria.

Why people stay is because there is a residue of hope and need in theperson to be normal and decent for all the degredation that you find in people who are addicts and in jail, there is a hunger to be a normal citizen and if you could kindle the hope that they could have this, the thing that probably is the most persuasive is the example of the older patients.

The thing that again and again has brought people into the programs and kept them there is to see some fellow that they knew on the street last year, the year before, now well-dressed with a family and respect.

They say: If he can do it, I can do it.

I think it is that type of a motivation that really is the starting point in rehabilitation.

Q Dr. Dole, we will leave the transcript now.

Doctor, have you ever had the occasion to meet professionally with officials associated with the Transit Authority?

A Yes.

Q Can you describe when that was?

A Unfortunately I can't remember the date. It was quite a number of years ago. I suppose it must be somewhere in the record but I would hate to guess at what date it was. It was sometime ago.

Q Was it in the 1970's?

A You know, I would hate even to guess there. As you get older, time collapses on you.

MR. BALBER: I think subsequent testimony will flesh out the date of that meeting inferentially.

Q Can you remember who was at that meeting?

A I remember Mr. McLaren and Mr. Van Riper.

Q Who is Mr. Van Riper identified as?

A I believe he is the head of the union for the Transit Workers or at least affiliated with them.

THE COURT: I did not get the name.

THE WITNESS: I remember two individuals at the meeting, a Mr. McLaren, a tall, distinguished gray-haired fellow who was--

THE COURT: It was the second name.

THE WITNESS: Mr. Van Riper was associated with the Transport Workers Union, as I remember.

THE COURT: How do you spell it?

MR. SUMMERS: V-a-n R-i-p-e-r.

Q What was discussed at that meeting, Doctor?

A I should complete the answer. There were a couple of other people as I recall along with them whose names I don't recall but it was not confined to the other two people.

pm Q Was oneof them medical director of the Transit Authority?

A I am afraid I don't remember.

Q What was discussed at that meeting?

A The problem that they saw jointly between the executive and the union of the Transit Authority is to be fair to the worker. It was recognized by --

MR. DUNN: Your Honor, I will object and move to strike the answer unless the witness testified as to what was said, what he said and what was said to him. He is hypothesizing now.

MR. BALBER: He is testifying as to the substance of what was said.

THE COURT: You are testifying as to the substance?

THE WITNESS: I am trying as best I can to state my recollection of the substance.

THE COURT: Go ahead.

A (Continuing) In any case they came jointly to see me on the feeling --

Q Did they tell you it was their feeling?

A Yes. They didn't indicate their feeling that it was a matter under discussion.

THE COURT: What was under discussion?

THE WITNESS: As to how they should deal with people who were addicts in the Transit Authority when people were either applying or discovered to be addicts and what would be a fair policy and I think in my recollection of this, I could see a middle ground because they both really were concerned for fairness.

Q Doctor, let us clarify.

Did they tell you they were considering hiring addicts?

THE COURT: Let us let him testify. He said they said they were concerned about fairness.

THE WITNESS: About the policy towards addicts and what precipitated it my recollection is, that there was a certain contest of people who were discovered to be addicts on the Transit Authirity employment and the union was raising the question whether the Authority had the right to terminate them on this ground.

I again, and it is only my impression, it is not accurately literal, told them that we were not prepared as a research university or institution to try to be a mediation or screening process which was the first question they made of me, which is really why they were there. I said, however, I did see inequity that there ought to be some independent expert, some competent authority independent from either interest that would look at it in terms of the medical status people and render an opinion on that ground and I therefore referred them to Beth Israel and to Dr. Trigg as being the most expert person I knew, so it was at my recommendation that subsequently they approached Beth Israel.

Q Did you have subsequent communication after that meeting with Mr. McLaren?

A I think that I must have, although I did not meet with him personally. I can't recall.

Q Did you talk with him?

A On the telephone, possibly, although I can't say for sure. I have not, however completed everything I had to say about the meeting. I tried at that time to differentiate the functional state of a person who is a heroin addict on the street, clearly an undependable person --

THE COURT: A clearly what?

THE WITNESS: An undependable person. A person who is a heroin user addicted on the street as a very undependable person. He is irregular on the job. His hunger is driving him to get drugs. He is likely to steal or be absentee and when he is on the job, he may take a shot in the washroom and become sedated, so he is clearly an unqualified employee.

I tried to be very firm in differentiating that type of disability from the fully functional state that I knew from our own research was the case with the methadone patients and I was most concerned that they didnot consufe the problem of the heroin addict with the state of a person being a stabilized methadone patient.

THE COURT: Was this in that conversation where Mr. McLaren and the other people came to see you?

THE WITNESS: Yes. I laid particular stress on that distinction at that time.

Q Dr. Dole, you stated that you declined to do any general screening for the Transit Authority?

A Yes.

Q Have you ever offered the services of your laboratory to Mr. McLaren and the Transit Authority?

A Yes. I said there was a large amount of evidence from our own testifying laboratory, and I had in mind Dr. Gordon's work to show that patients stabilized on methadone had normal functions and capable of performing any job that required neuro-motor coordination.
I said tohim if he felt unpersuaded by the general data we had, that if he wanted to have specific testimony cases of people who were bona fide methadone patients, we would check them out with this battery of tests and see if they

specifically were qualified or showed disability.

Q Has Mr. McLaren or have any other officials of the Transit Authority ever accepted your offer?

A I know that at least one of the test cases have been tested by Dr. Gordon.

Q You are referring to the plaintiffs in this lawsuit?

A I presume. Actually I haven't kept very close track of the interaction because I delegated the matter to Dr. Norman Gordon and I am sure he could testify more on the testing specifically done.

THE COURT: Do I understand that you offered to Mr. McLaren that if he had specific prospective employees or specific -- well, specific prospective employees, that your laboratory would test these people out?

THE WITNESS: Yes, sir. I said to him that we were a research group and we could not do hundreds of thousands of routine testifying, but insofar as it would serve to clarify the point and principle, it would certainly be acceptable to us to do a limited number that he would send to us, or not necessarily, but the medical people or anybody in the Transit group that he wanted to send.

Q Other than that person you mentioned, to your knowledge have any other persons referred to Dr. Gordon?

A Not, not that I know of.

MR. BALBER: Thank you.

THE COURT: Cross examination.

CROSS EXAMINATION

BY MR. DUNN:

Q Good afternoon, Doctor.

A Good afternoon.

Q Dr. Dole, on direct examination you stated that you would not permit one of your patients in a methadone maintenance treatment program to be referred to as an addict?

A That is right, sir.

Q What is an addict?

A An addict is a person who administers drugs to himself under his own compulsions and does so in a destructive way as as to impair his function.

Q Would that include the iatrogenic addict, Doctor?

A Would you clarify the question as to what you mean by that?

Q Do you know what the term iatrogenic means?

A Yes, but if a person let us say is a cancer patient and he is given narcotic drugs to relieve his distress of cancer pain, he will become physically dependent on the drug. I regard him as a patient.

Now let us say his cancer is cured and he goes out on the streets after leaving medical care and seeks illicit drugs and is injecting himself, then he is an addict. His original problem was iatrogenic, but the issue is whether he is taking drugs under his own compulsion or whether he is taking drugs prescribed by a physician.

Q Isn't that a distinction without a difference? Isn't addiction -- can it not be specifically defined as pertaining to a person who has a physical dependence on a drug and if the drug is withdrawn, a certain syndrome would be presented?

A The word addiction has two parts to the meaning and it tends to be used by people for the part they want to emphasize. The two parts in the word addiction are one, the purely pharmacological aspect of physical dependence and two, the psychological compulsive aspect of drug seeking behavior.

Now, in my terminology, the important part, for practical purposes of addiction, is the drug seeking behavior because that is the part that is destructive to normal life and behavior. I regard a person as an addict when he is exhibiting this drug seeking behavior and he is administering illicit drugs to himself merely to generate physical dependence is not enough to indict him with the perjorative of "addict".

Q It is a medical term rather than a perjorative term?

THE COURT: I don't see where I am getting by hearing a discussion of the term "addict"?

MR.DUNN: There is a statement with regard --

THE COURT: I think we are beyond the labeling stage. He just said as a matter of helping these people have self-respect he calls these people patients and not addicts. Let us not labor that.

Q Did you at one time expound a theory that was described as the metabolic change theory or something of that nature?

A Yes.

Q Would you describe for us what that theory stood for?

A When a human being or an animal is exposed to large amounts of narcotic drugs repeatedly given over a period of time, you establish a condition of physical dependence. If now the drug is stopped, the man or the animal experiences a set of withdrawal symptoms.

In the older theory, these withdrawal symptoms were limited to a few days or a week or two at the most, after which it was postulated that the nervous system went back to its original state and showed no after effects.

The theory I offered, is that this return to the nervous system is not that complete and there may well be for long periods of time after detoxification, certain dysphoria symptoms that are a contributing cause to the relapse.

The theory is offered as an explanation for a phenomenon which is well recognized in the literature that long standing narcotic addicts after detoxification and psycho-therapy and what not then return to the community with no further treatment of a very strong probability of relapse.

Q Do you presently subscribe to that theory, Doctor?

A Yes.

Q Can that theory be stated another way and that is, that changes take place, metabolic changes take place in the brain as a result of prolonged drug usage and/or narcotic usage, which changes are virtually irreversible?

A We don't know how reversible they are. Certainly they are fully reversible by all evidence we have on methadone treatment. The striking thing is that whatever the dysphoric symptoms or problems that lead to relapse, the narcotic drugs, are extinguished by proper methadone treatment so we have at our disposal in methadone treatment, a process or treatment by which we could bring the ex-addit, the post heroin person back to completely normal function by every test that we have been able to discover.

Q You testified at length about the pharmacological effect of methadone. On what site or sites does methadone operate?

A There is a great deal of research in the literature and also in my laboratory on this point. The sites of action still remain to be clearly identified but there is a good deal of evidence that the limbic, system of the nervous system is involved very much in this.

THE COURT: The what?

THE WITNESS: The limbic, l-i-m-b-i-c. That is a rather complex network of neuclei in tracks which is called the paleo cortex and it is involved with perceptions of pain among other things so it is clear in some ways yet to be elucidated, narcotic drugs do act upon this pain processing receptor area of the brain.

Q Can you tell us what neuro transmitters are?

A Yes. Neuro transmitters are bioamines, which are the means by which a nervous impulse is transmitted from one neuron to the next across a synaptic gap.

Q What effect, if any, does methadone have on neuro transmitter biosynthesis?

A I should answer in a more broad way. Everything that in any way affects brain function must affect neuro transmitter turnover because the neuro transmitter turnover is the process by which the brain functions so that the process of memory or the process of any other experience or any drug at all that exhibits itself by any behavioral change, must involve some change in the neuro transmitter turnover.

As to whether there is any specific relation of narcotic to any specific neuro transmitter, is a matter that has been very much discussed and the current opinion is that there is no specific neuro transmitter narcotic tie-in because all the transmitters show some altered turnover at different stages of narcotic action.

Q Can you identify the various research projects that address themselves to neuro transmitter biosynthesis?

A Yes. It is one of the more active fields in the game now and in fact three years ago I wrote a large review on the subject for Biochemical Reviews with some couple of hundred references. It is such an overwhelming field, I hate to begin to summarize it now, but there are at least a dozen laboratories that have a major interest in neuro chemistry and various aspects of it in relation to narcotics.

THE COURT: If you could keep turning a little bit towards me, I am losing you.

What is your conclusion about the neuro transmitter problem? What is the current conclusion vis-a-vis methadone?

THE WITNESS: In the first place, neuro transmitters are the fundamental instruments of nervous system function so that any nerve impulse involves some change in some turnover of some transmitter at some point and the whole brain is just a seething ferment of neuro transmitter turnover. That is by chemical definition of what is going in. Any substance that works in the brain is obviously going to work with this medical use, so it is not a particularly interesting question to say will there be any change in neuro transmitters with any drug because obviously there must be. The more interesting question scientifically is whether a drug action can be in some sense identified with any particular kind of a neuro transmitter turnover and that means different locations of the brain or different chemical neuro transmitters because there are half a dozen neuro transmitters such as acetylcholine, norepinephrine, dopamine and so on and the question is, will we understand how the narcotic works by studying a particular neuro transmitter. The answer is at the present time probably not.

THE COURT: Maybe this is far too blunt, but, I guess again in my language if somebody asked about problems of neuro transmitters versus methadone I wonder if there is some effect from methadone on these viable processes which will hurt somebody's abilities and that is really what it all boils down to and can you say anything about that?

THE WITNESS: Yes, I would say we come back to the direct testimony of the issue separate from theory. That is, what is the ability of an animal exposed to methadone under different conditions as measured by reflex time or cognitive functions or memory or emotional problems or what any other measure of what you discover reflexes of the brain chemistry and measured in those terms, we have not been able to discover any deficit in function in our methadone patients.

Q Isn't your opinion, Doctor, that methadone has some effect on the chemistry of the brain?

THE COURT: I think he said-- you know, some effect on the chemistry of the brain, I think he has just said "yes" because that's the-- apparently methadone gets to the brain but that doesn't help us.

Q To what extent, if any, does insulin react on the cells in the brain if you know, Doctor?

A I really don't know in a direct sense. Obviously, insulin reacts very much on the cells of the brain by virtue of its effect on the blood sugar, which is the critical metabolizer of the brain.

You can produce, of course, convulsions by giving injections of insulin to a person.

Q You published a paper that appeared in the Journal of the American Medical Association, November 12, 1973, entitled "Detoxification of Rehabilitative Methadone-Maintained Patients"; did you not?

A Yes, sir.

Q May I read to you just a sentence from this paper:

"The present study has shown that a substantial fraction of rehabilitated and motivated methadone-maintenance patients can be successfully withdrawn and that an unsuccessful first trial or withdrawal may be followed by success in a subsequent attempt."

A Yes, sir.

Q Was that your opinion at the time, Doctor?

A Yes, sir.

Q Is that your opinion today?

A Yes, sir.

Q You authored, I believe, a paper that appeared in the New York State Journal of Medicine, Volume 74, No. 7, July 1974, entitled "Rehabilitation of Methadone Patients"; did you not, sir?

A Yes, sir. Probably a little earlier than the date you cite. But that's when that was.

Q That's the date that appears on the paper.

Would it refresh your recollection to look at it?

A It is unimportant.

THE COURT: Go ahead.

A I wrote the paper. Yes.

Q You agree it was sometime in 1974?

THE COURT: If you have the date--

A I believe the paper we are talking about, "Rehabilitation of Methadone Patients" I wrote at an earlier date, if that's material. It may well be misprinted but I would be prepared in any case to discuss the content of the paper.

Q May I read to you, Doctor, one sentence that appears in this paper?

"Clinically we also are seeing symptoms of insomnia, irritability, poor performance on the job, alcoholism, and in some cases relapse to heroin with disturbing frequency, in patients who have been detoxified after an apparently successful rehabilitation in a methadone program."

Were those your words, Doctor?

A Yes, sir.

Q Was that your opinion at the time you wrote the article?

A Yes.

Q Is it your opinion now?

A Yes.

Q Do you find a conflict between the two statements?

A No. In the first place, anybody that's on a methadone program can be detoxified and without too much problem.

Secondly, virtually all the people who are detoxified will snow some symptoms afterwards which are not really due to the methadone but are due to return to the, some of tne symptoms that they had shown in earlier detoxifications and these are the symptoms of restlessness and irritability.

Q Of what, Doctor?

A Restlessness, irritability, maybe insomnia.

In a great many patients they pass through this temporary phase of symptoms during a period of a few weeks or a few months and come out and they are fairly comfortable and they are functional.

In some cases these symptoms persist and in some cases they apparently force the person back to heroin.

Now, taking the overview of this business, what I protest against are public policies or public opinion that somehow or other set up detoxification as an obligatory target for people.

I believe that should be left to medical judgment.

On the other hand, in our own practice and in our advice to any doctors that are involved in this, we say, of course, consider detoxification and discuss it with the patient. Make it available. And if the person does well, everybody rejoices.

If the person gets symptoms after withdrawal, we always have the opportunity to come back temporarily to the program and try it at a later time.

So I don't see any inconsistency of the two businesses. These are exactly the same parts to the problem, just looking at the early stage and the late stage.

Q The early stage, you state a substantial fraction of rehabilitated patients can successfully be withdrawn; the later statement refers to disturbing frequency.

THE COURT: I have heard the statements.

A Yes. Well, perhaps you would clarify the question for me now.

Q Well, from the time that you authored the first article until the time that you authored the second article and up to the present, have you observed, as you describe, a disturbing frequency of patients who fail in detoxification, fail to remain detoxified, over a period of time?

A I am afraid I have sort of lost the question.

Could you sharpen it up for me?

THE COURT: You are asking for the third time if he believes what he put in the 1974 paper, and he hasn't really repudiated it - he has given his explanation of the two statements in conjunction, and do you have any more questions on that?

MR. DUNN: Yes, I do, your Honor.

THE COURT: All right.

Q Have you studied, Dr. Dole, the patients who have detoxified from your programs with a view to determining what percentage remain successfully detoxified?

A We have the studies now in progress. Other than that we have only unsystematic data.

Q Do you have an opinion with respect to --

A Yes, I have.

First of all, it depends, I think, upon how long the person has been addicted prior to treatment, and, secondly, upon the age group one deals with, and thirdly, upon the motivation of the patient.

The most favorable group to be detoxified and to remain in a very good functional state are people who are relatively young, who have a relatively short period of prior addiction before treatment and are well-motivated linked into job, family and responsibility.

The persons that I am inclined to be conservative, certainly not urge detoxification, are ones who have had a much longer time of addiction and are older people.

Q Do you have as one of the goals in your treatment program detoxification?

A No, sir. Not as such. It is a desirable result but the central goal of the program is to enable a person to be functionally normal, to live a normal life.

THE COURT: I am going to interrupt here.

The question that hasoccurred to me several times in your testimony is this-- well, I don't know quite how to say it but Mr. Balber asked you questions about the overall efficacy of the programs and so forth.

What I would like to get a better idea of is the types of people-- not statistics and not subjects of some psychomotor tests, but what are the types of people that are patients in these programs.

I am getting the strong impression from what you have said and other testimony, particularly Dr. Cushing of the St. Luke's program, that there is a whole range of problems in addition to just the physical problem to be handled by taking the dose.

THE WITNESS: Right.

THE COURT: Okay.

Now, is there any way you can expand on that and help me understand more about the types of people in these programs, this 40,000.

If you just start, maybe I will think of ways to follow it up. And let's talk about the overall person because, after all, you are the Transit Authority, you are not hiring a part of a person. You are not hiring his psychomotor or something, you are hiring a whole person. Right?

THE WITNESS: Let's talk, then, in tems of prototypes, that my be useful.

One sort of person that you will see in the program and probably the, numerically the predominant prototype would be someone who is black or Puerto Rican, who is brought up in a disadvantaged neighborhood, say East Harlem or the Bronx or Brooklyn or some neighborhood where an enormous exposure to narcotics drugs occurred when he was in adolescence. They were all over the streets and the action was to fool around with drugs and gangs were using it and the pusher was there. The big man in the neighborhood was the fellow with alligator shoes selling the stuff.

It was the sense of activity involved with it and it was kind of the "in" thing to do.

In some ways, if you are a kid in that cultural group in that neighborhood and you haven't ever tried narcotics, you are out of it. You are a deviant. In some ways for that kid in that time in that neighborhood a natural thing to do, at least out of curiosity, is to try it.

A certain percentage of these kids, surprisingly not all of them, get hooked on narcotics. Not every kid that fooled around and tried narcotics became a confirmed addict. But it was the thing to do, particularly in the '50's, early '60's, in these neighborhoods. That's where the action was.

Now, this is put against the background of all the social disabilities that comes from the ghetto and the disadvantage of minority group status and the inadequacies of the educational system, the heavy drop-outs and the absence of any other recreational or employment opportunities and you have a very disintegrated social situation.

Very soon, if a kid at this stage of the game dropped out of school and now with a drug habit, it is going to cost him $25 or $30 or $40 or $50 a day, very soon he is heavily involved into theft, criminal activities, to get money for drugs and within a very short time the probabilities are he is now caught up in the courts. He is arrested, he is convicted, he is the kid I see when I work out because I have been working in the prison for more than four years, and I see these kids. I have seen them in the Tombs before they closed it and in other places.

You now are adding social disabilities to a pharmacological problem.

THE COURT: Let's see. You start out with the ghetto environment. The fellow who has become the addict, he has an even worse life style. You have described he has this habit. I mean what more can you tell me about his life style and his problems after he becomes addicted?

THE WITNESS: He now, say, has a drug habit in the languatc that is going to cost $30 or $40 or $50, maybe more dollars a day, and, of course, the problem is how can the black kid with no job and no family and no skills get that money honestly. He can't. He now is involved in some criminal activity which is generally either theft or drug-selling.

So he becomes an instrument to spread more drug addiction in the neighborhood by his drug-selling and he also becomes a menace to the whole commercial community because he is robbing the stores and so on.

THE COURT: His mental processes, where you and I would seek relief or pleasure from one or another thing, he is going after heroin, right?

THE WITNESS: Yes, he is hooked on it now.

THE COURT: Which means he is hooked, which means -- tell me some of the things that means.

THE WITNESS: That means that he has to get three, four or five shots every day. He wakes up sick in the morning. What is on his mind only is where he is going to get that next shot. He is on the run all the time trying to hustle to get money, to steal, to buy drugs, to shoot the drugs and then he is very soon on the hustle to get more. He almost never is able to even get ahead of the game and build up a supply. He is always desperately on the run for the next shot so his life is totally disrupted.

He very likely will have alienated himself from any family or friends because his desperation will be so great that he will have stolen his own family's television set or clothes or shoes or anything he could to sell and get drugs.

So he becomes a pariah, even in his own community. He becomes a footless person living in basements and roofs, benches. Totally floating. And then caught up and beginning to develop a progressively more of a criminal record as he builds up so he has become progressively more isolated and lost to society.

Starting with the person who is disadvantaged in the first place, he becomes in a few years into something that is such a hopeless situation. His own self-respect and degradation is so great he has no hope for himself.

It is a very major step for somebody, to be able to be believable to him and actually somebody as remote as I am from that environment,couldn't really walk into that scene and be that convinced.

THE COURT: What causes him to get-- you are sort of tracing this.

THE WITNESS: Yes.

THE COURT: This is a prototype.

THE WITNESS: Yes.

THE COURT: What is the path to the methadone clinic? Has he got some interim steps?

THE WITNESS: The thing that's been most powerful to bring a kid to treatment is to see an example of someone he had known previously on the street now well-dressed, with self-respect, a job, a family, and he begins to figure, if that can happen to so and so, then there is hope for me.

That is certainly the dynamics of it.

The other thing that can bring a fellow like this to treatment is simply the desperation of a narcotic habit that's gotten so out of control he is sick all the time. He can't run fast enough to get enough drug even to keep himself from getting sick all the time, so he checks in for detoxification and in that situation.

Another avenue has been in the jails and some four years ago, Commissioner Malcolm asked me if I would help with the sick addicts in the jails because, as you recall, they were loaded with addicts who were on the floor vomiting, suicides, and the like.

And so with the Commissioner's help I moved into the correction system with a team of my methadone patients to work with me and we set up a treatment program for the sick addicts in the jails, just to give them relief, just to take care of their acute sickness and give them one week of treatment with a decreasing dose, just to help them come off the habit.

And this generated an enormous amount of gratitude, goodwill. It was so dramatic that this was in the Tombs on the 9th Floor after the riots had blown the place up. I came in with my team three months later. Two weeks after this had started, I was able to take the Commissioner on a tour of his own cell blocks and his addicts were putting their hands out through the bars to shake his hand. It was a very moving thing.

What is not realized about addicts is that there is a tremendous need, receptivity for understanding.

THE COURT: The person, let's take the person who is in the situation you described. He is the ghetto fellow. He has gotten into the kind of isolated life and so forth. He starts, comes to a methadone clinic.

If you could possibly just describe-- obviously, as you have indicated, more is done for him and more has to be done than just give him this dose every day.

So what is his--

THE WITNESS: His first anchor point is the ex-addict, senior methadone - successful methadone patient who is now a counsellor in the program and a few are very respected-- it is a very respected job offered to one percent of our patients to come back and work for the program and it is that man or woman who represents the first important contact, link to the program. There is a common ability to speak, to understand, and oftentimes these patients are so destitute --

THE COURT: They are so what?

THE WITNESS: So destitute. They have so little. They have no place to sleep tonight. They have no meal to eat for lunch. They are that totally destitute that we arrange for somebody to take them home so they can just have the most animal needs satisfied.

And there begins to build up in a good clinic some feeling that there are people that understand the problem there and that needs are being met in the order of priorities that make sense.

So the first engagement, the first involvement must be to develop a relation of belief between the patient and the clinic. He must become in some sense what we take for granted when we talk about a patient, somebody who trusts his doctor.

That's almost in the nature of sort of first aid.

Now, then, it takes a while for a person to settle down. The mán has been running essentially, either in jail or running on the streets for ten years, it is a slow process just to settle down.

And sometimes we tell a person, just take it easy, just come here every day; while you are here, we can talk. Se have some friends. And the problem of what to do with his spare time is a very real one and we have various types of recreational programs and projects we sponsor. We set up projects where some of these new patients can go to the theatre. They have never been to a show or museums or whatever. Just a feeling of touching society.

THE COURT: As you are talking, you see, I am trying to relate what you are saying to dependability as an employee.

THE WITNESS: I would say at this stage of the game--

THE COURT: Obviously, when this man walks into themethadone clinic, he is as undependable as you said the heroin street addict. He is practically not advanced beyond that, right?

THE WITNESS: Right.

THE COURT: And the qualities which I think you obviously had in mind for a dependable employee in a general sense, he is in a risky situation-- well, let me ask you:

During these first stages, he still is in a risky situation, is he not?

THE WITNESS: Yes, sir.

I would say that a position that we felt very strongly in our programs is that although stable employment is clearly one of the main targets of any social stability, it is our job and the program's to bring a man or a woman to the point where he or she is ready for it.

pm

THE COURT: What are the things that you, in this prototype individual you have talked about, what are the things that go on, what are his characteristics while he is in the initial stages that make him either undesirable or desirable for employment in your view of evaluating?

THE WITNESS: The reliability of a man coming say to his clinic for appointment is already an important point in ordering up his life. So, you would certainly expert that this person will begin and develop regular habits of responsible clinic attendance, whatever schedule is for him.

Secondly, his urine is being monitored so you know if he is taking illicit drugs and you expect in a favorable case this illicit drug use will quickly terminate and in many cases it terminates from day one. There is no more illicit drug use after he is in the program.

Thirdly, you are concerned about his housing and living conditions, if he is beginning to develop a stable way of living and let us say at this point in the development, he is on welfare support so he has a modestly legitimate sort of support and maybe he is back with his parents if he is young.

You are concerned about his family arrangements and the outlook for somebody is far better for somebody who has some type of family structure, somebody that cares about him, if he has a wife or common law wife or parental family or some group he is with that is decent and stable. You begin to get a feeling he is developing stability in his life style. Then you begin to feel that he is at least potentially ready to ass-me the type of responsibility that a man should that is taking a job.

THE COURT: If you have this prototype, is there any way you could indicate to me the average length or usual length of time that it takes to get this man into a situation where you call him stable, reliable, potentially employable I think is the term you used? Is it just so fluid and variable that you can't describe it in that way or is there something that is observable as a usual period of time?

THE WITNESS: It depends where the patient starts from. At one extreme some few years ago when I was working in the Tombs I set up a program with the assistance of others in the criminal justice system to bring out some of these detainees into a probationary state or a deferred sentence into a treatment program. I was dealing with some of the most socially deprived and socially deteriorated people I had ever seen. For people like that it is a pretty long road to get to a state where they have middle class job liability.

On the other side, a more typical type

of job skills or potential and at the most favorable side, you deal with people who have even beenable to hold a job while they are addicted and they may have skills.

THE COURT: We had this Dr. Cushman as you know. I think he gave me a statistics of about 25 per cent of the people that he knows -- he wuld say 25 per cent have been able to keep jobs.

THE WITNESS: Before.

THE COURT: Even thorugh the heroin problem so they have a fairly current job record when they go into the methadone situation.

Would you more or less agree with that?

THE WITNESS: Yes, I think that is a fair figure for the people he had in his clinic. He had a certain cross section on the west side.

THE COURT: Is it better or worse?

THE WITNESS: I would say he is dealing with people with a lot of problems butnot the very worse.

THE COURT: He is not dealing with the worst. Where would the worst be?

THE WITNESS: The sort of people that I pulled out of the Tombs.

THE COURT: What area of the city?

THE WITNESS: They came from Harlem or Bedford

Stuyvestant, some in the Bronx. It wasn't just the area of the city. I was dealing with people up on the 9th floor that had never succeeded in anything. They were just the most ravaged individuals. They never even got around to applying for a treatment program.

THE COURT: Would you be able to tell me out of the 40,000 that are currently active methadone patients, about how many you would say, what percentage would have been able to keep their employment going through the heroin, methadone period?

THE WITNESS: I would think taking that total pool that the Cushman percentage is about right.

THE COURT: I think I asked you a question about the length of time until you could get -- until a person could be potentially employable and I think you were telling me it varies greatly and let us approach it another way:

Are you able to discern, or are the people who are supervising the clinics able to discern enough about these people to be able to determine whether they are potentially reliable employees?

THE WITNESS: Yes, sir. I think that is quite definitely possible because the exposure of a patient to the clinic is so intimate and so continuous that you have good judgment as to his performance and his abilities. You know how well he keeps appointments. You know what he is doing so far as taking licit or illicit medication. You know how he is living, you know what efforts he is making towards getting a job or otherwise participating in normal activities. You know more about a man coming to a methadone clinic than virtually any other human contact that you will have with another human being.

THE COURT: Let us suppose you were in the personnel department of the Transit Authority and someone came to you and said "I was a heroin addict for five years. I have been on a methadone program for eight months." This may seem like a strange hypothesis, but let us suppose the Transit Authority personnel man is unable to get any information from the methadone program, he is just relegated to his own normal interviewing and so forth. What I am trying to get at is this: Would he be able to form a very good judgmentas to the employability?

My question is, would he without that intimate information that the methadone people had, would the Transit Authority personnel fellow be able to form a very goodjudgment as to whether this man could run a subway train or handle heavy equipment or sweep floors or what?

THE WITNESS: Well, sir, I would like to ask how the personnel man makes that judgment in any case, because suppose you have somebody who is, let us say, of a minority status and claims to be physically able and sayd he wants a job there. I don't know what their processes are.

THE COURT: I am not in their personnel work so I don't know, either, but I think my question still has some meaning in this respect: You still know one thing. You know here is a man who has the problems associated with several years of heroin addiction and I am trying to ask you this: Your real question at that point, I would assume, is what are the risks inherent with this man becuase of his drug history, right? That is what we are really focusing on and obviously if he was still on heroin, that would be enough to knock him out right there because the risk would be very great, right?

THE WITNESS: That is right.

THE COURT: If he tells you he has been on heroin for five years but is now on a methadone program, you would, if you were sitting htere,you would realize there might be a risk associated with that history, right?

THE WITNESS: That is right.

THE COURT: And you would want to make a judgment about that subject, right?

THE WITNESS: Right.

THE COURT: Would you, without quite extensive expert judgment of the methadone clinic, you would not want to make that judgment, would you?

THE WITNESS: I would want more advice. Essentially that question that you are asking me brought Mr. McLaren and Mr. Van Riper to see me.

THE COURT: Objection.

This would present a problem where you would definitely need an unusual amount of advice and help, right?

THE WITNESS: Yes, sir, I would think so.

THE COURT: What you are telling me is, a good experienced person in a methadone clinic could give you that advice?

THE WITNESS: Or a person who is a very experienced person in the field of addiction with knowledge of methadone treatment and other treatments.

If I may anticipate, that is why I suggested to them that they approach Beth Israel Medical Center who has had an enormous experience in this field and particularly Dr. Trigg who has probably had more experience in detoxification of people than anybody else in the world and involve him as a consultant under retainer. Let him be a referee, do not expect any inexperienced personnel man or any inexperienced doctor to make a judgment that involves any judgment in the field of addiction and knowledge of addicts that the average doctor doesn't have. I would say fine. Don't close your mind to the matter and don't try to solve this by some formula. Draw expertise as you need it and I said here is a place that I can recommend that you go. So, I would think all I could do for them is to provide a procedure to be followed.

THE COURT: Would you have any idea -- let us take kind of the proverbial subway job, that is, the fellow who is the motorman on a subway train.

I would imagine you have a pretty good idea what is required for that job. We took a tour and you probably know about as much sitting here as I do from the tour. They have very serious responsibilities, right?

THE WITNESS: Yes.

THE COURT: They have a lot of lives in their hands, right?

THE WITNESS: Yes.

THE COURT: Let us take that job. Let us take the 60,000 methadone patients. Can you give me any idea -- let me start this way: Would there be any people who had been narcotics addicts for two years, be enrolled in a methadone program for six months that you would feel could be hired as a motorman on a subway?

THE WITNESS: Yes, sir. If you speak only in terms of the medical, the physiological performance --

THE COURT: No, I am not and I am not doing that. I am saying considering this whole problem, the history of the man in the whole sense, and I am starting with the extreme; do you feel there are any of these people that you would feel could be hired under sound judgment to be a motorman in a subway car, and I am talking about a heroin addict for two years, someone who has been on a good methadone program for six months?

THE WITNESS: Yes, sir. I would say probably the majority could qualify.

THE COURT: Why do you say that?

THE WITNESS: Because within a few weeks people become surprisingly normal if they start off with a basic state of health, that is, not any complications, just addicts, and a very high percentage of people are well motivated and responsible, responsive to the opportunities. Again, we have to say what group are we starting with. I would think it would be quite an achievement to pull 100 people out of the 9th floor of the Tombs and make motormen out of them in six months but on the otherhand there are other people holding jobs far more responsible than this all through the early stages of their treatment.

THE COURT: Like what jobs?

THE WITNESS: Power tools, skilled operators in machine shops and in various manufacturing industries, construction people.

THE COURT: I would have expected you to answer my question yes but I wouldn't have expected an answer about the majority.

Let us go to the prototype we are talking about. The fellow that has the history of the heroin addiction, to get on background, the isolation, the drug culture life style. What I am really getting at is this: In a period like six months, is that kind of a person -- isn't he still at least enough of a risk that you don't want to put him doing something like running a subway car where he has a lot of people's lives at stake -- you get the picture?

THE WITNESS: Frankly, I am not sure that I want methadone patients to be made motormen at any time, because judging from the way they have so many crackups, I would hate to have them blame it on methadone patients.

THE COURT: Let us not get into that.

THE WITNESS: I am serious about it. One of the things I brought up at this meeting with Mr. McLaren. I could very well understand from a public relations' point of view a policy that would exclude people, say methadone patients from such a job as being a motorman and I wuld moreover concur in it on policy grounds because just statistically you are going to get a certain number of problems and I would hate to think that the Daily News would find this a headliney type of thing and it would hurt so many people because it would lend itself to such sensational journalism.

THE COURT: I want to make it clear with you --

THE WITNESS: I am speaking now in only protecting methadone patients.

THE COURT: You are speaking seriously and not snidely of the Transit Authority.

THE WITNESS: Your Honor, I don't mean to be snide. Addicts in general are subject to so many prejudices. If anything you try to do and you have 100 successful people and one person who gets into trouble, the Daily News headlines that one person as you know. I am constantly concerned to protect opportunities for methadone patients because for every one problem you have dozens, maybe hundreds of worthy people.

THE COURT: Aside from that, aside from what you have been talking about, let us go back to our prototype six months, I used that for no particular good reason but it is there.

What I am trying to think of, looking at this whole man, would you not find a risk at that stage that he might have really gotten past the life style and so forth, where he is quite reliable enough to take this very sensitive job?

I am probably not putting it right?

THE WITNESS: We come back to the question of individual judgment. If you have an assortment of people in any clinic, they are people of different levels of reliability and you could choose exaples to illustrate anything.

I certainly would not want to leave it that you take almost anybody into a methadone clinic and in six months you have a collection of sort of certified angels. This is a problem. You have to judge people by their own performance.

I would say also, one has to take the perspective of the culture standard. There is another real problem. We are dealing with disadvantaged culturally deprived people.

Many of the problems is whether they are reliable enough to show up on the job. You are dealing with culture deprived individuals. We have a middle class type of compulsion that if we have a job, we show up.

There are other people that don't feel that drive and one of the tests on this sort of thing, if you want to take the hypothetical example is, if one were to have, let us say a collection of people who are methadone patients at the six months interval and a comparison group of say 100 disadvantaged minority people from the same cultural group, same neighborhood, no addict how employable would they be? I would say the methadone patients at this stage of the game are probably more employable than their comparison group.

One of the successes in the methadone program is that the employers have been so pleaded that they have opened the way for more employment.

THE COURT: That leads me to another question. In the testimony of Dr. -- the lady who --

MR. BALBER: Dr. Carey? Eileen Wolkstein?

THE COURT: She described these pilot programs with Con Ed, J. C. Penney, Equitable Life and so forth, Chemical Bank.

She said, if I am correct, that, if my memory is correct, that the people furnished to these employers had been selected and I don't think she put it the way I am putting it, but I would draw the inference that this was a pretty highly select group and I think she said that in all or most cases the criterion that the employer had required, that there be a continuous current work record. Okay.

I received the impression that she was drawing from a very distinct minority in furnishing people for these pilot programs and I think that may point up the line of questioning I was trying to address to you.

When we're talking about people who could sensibly be employed for subway motormen or some of these other similar jobs, are we talking about a very select minority of the methadone patients or are we talking about something else, and I start with the pilot program where I got the impression it was very select.

THE WITNESS: Yes, sir.

I was, as you probably recall, involved in it. I set it up.

THE COURT: Sure.

THE WITNESS: With Dr. Doyle of Con Edison and others. This was a special research project and one of the really limiting factors in the ability to choose patients for this test study was whether they had job skills.

This now goes beyond the question as to whether at just the physiological level they have normal reflexes.

It goes beyond the question as to whether they have motivation and general reliability.

It goes into the questions whether they have typing skills or various other types of mechanical aptitudes that qualify them for jobs, so the highest degree of selection there was in terms of the job skills rather than the medical questions.

THE COURT: Are you telling me that if there had not been the requirement of the specific job skills, this could have been-- these people could have been drawn from the majority of the methadone patients or--

THE WITNESS: Yes, sir. Certainly Miss Wolkstein for this experiment was working with a very limited number of clinics. She was not drawing on the total methadone clinics. Her area is with the Beth Israel program and primarily directed to the handful of clinics that are close to that base, so it was not an attempt to try to plumb -the scope of the entire market, but it was an attempt to respond to an experiment that the industry wanted us to make.

They had questions somewhat similar to yours and they were: "Should we have a policy to just arbitrarily exclude all methadone patients?"

We said, "Certainly not."

They said: All right, we will set up a controlled experiment in which you send us methadone patients that meet certain specifications for certain jobs we have open and we will follow them very closely and compare them with people that don't have an addiction history and we will see whether in fact these people perform.

And the question to be tested there is whether methadone just per se invalidates a person and incapacitates a person for a job land the answer was very clear.

These people performed as well or better than the comparison group. So that was the question being asked and the answer was in terms of the selected people.

But it didn't address itself to the question -- how wide a pool can one draw from to deliver people of this quality.

THE COURT: Okay.

The thing is, I have in a sense got to isolate the job skill problem from the problems of -- that relate to the heroin addiction and life style.

My responsibility is not concerned with whether people have typing skills or not. I guess it makes it a little hard but would it be possible to -- suppose a man-- suppose we took a methadone patient or we took 40 or 50, some number,and we were interested in knowing whether it would be sound judgment to employ those people as motormen on subway cars, subway trains.

We are not interested in the aspect of job skill, whether they know how to run subway trains, not the rules; that we put aside, right?

THE WITNESS: Right.

THE COURT: We are interested only in the question of whether the heroin history and the methadone treatment presently being administered,whether that part of the man, the life style problem and so forth, whether he is sufficiently reliable, sufficiently capable -- what I am asking is, would it be possible to take a group of people and sensibly evaluate them as real live human beings on the question of whether they have got the qualities I'm talking about?

THE WITNESS: Yes, sir, undoubtedly. As a matter of fact, if I put myself in the position of a personnel man in the Transit Authority, I would consider it a very serious responsibility to ask that question about anybody who was an applicant for a job and I presume if I have the experience in this, I will have had certain tests that I look to.

For instance, one thing that is most urgently important is that you do all you can to exclude that this man should be an alcoholic because in our experience, for instance, studying the driving skills, the records of methadone patients, methadone patients,looking at just accidents in driving, are normal except those that have an alcohol problem, and it is well-known from other studies that the greatest source of poor performance is alcoholics.

If I were a personnal man I would be very concerned to make sure I'm not picking people that are alcoholics and letting them be motormen, and you would have to get some judgment as to a man's mechanical aptitudes and reflex time.

In general, what I would say if I were the personnel man in this situation is that there is enough evidence to say that methadone per se does not incapacitate a man from the job so that that would not be, per se, the reason for exclusion but I'm still left with the responsibility of judging in the postive sense the man's aptitude for the job, methadone or not.

THE COURT: Okay.

I think I have finished with my questions.

Do you have anything more?

MR. DUNN: Yes, I have one or two, your Honor.

THE COURT: Let me just pass along this thought.

I think we have had a great deal of testimony about the characteristics of methadone, the effects, the characteristics of methadone people and heroin people in a general way and that's been extremely helpful, but more and more, I am coming to feel that nobody has really tried to take examples of real live human methadone people and see whether they would be capable of being motormen or maintenance worker Class B or whatever you have.

The plaintiffs certainly did not begin to do it. There was not one bit of testimony attempting to relate these general propositions to specific jobs, much less trying to take examples of real human beings and relate them, except I guess to the plaintiffs themselves. But that was very sketchy.

There was very little asked the plaintiffs, I don't think they bothered to ask-- I don't say bothered -- I don't mean to be demeaning, but my memory is the plaintiff's lawyers did not ask the plaintiffs much of anything about their work, so the plaintiffs' case was presented abstractly without trying to tie it in any way to qualifications of these specific jobs.

Really, the defendants have -- the defendants, under some prodding from me, came up with evidence about the nature of the specific jobs but again, so far I haven't heard any evidence really tying in any direct, concrete way the characteristics of real live methadone people to the jobs, whether they are capable or not capable, whether it would be sound judgment to hire them or whether the risks are too great so they can't be hired.

THE WITNESS: Your Honor, could I make a suggestion on that point?

THE COURT: Yes. I will say one more thing.

I think the thing that you offered to the Transit Authority originally to evaluage specific live people really gets it away from the abstract theory. It is not a bad idea.

Go ahead.

THE WITNESS: If we had a listing of job descriptions with the type of responsibilities that are involved, the hours, any other special demands, we do have enough very real life experience in comparable jobs.

It would be a bit of work but possible to take, let's say, a dozen jobs, in categories selected as being ones of demanding quality in the Transit Authority, and say let us look through the very large experience of these 40,000 people and we can match up, we can give examples of people doing really quite comparable jobs in manufacturing or in various other industries.

THE COURT: That doesn't help me. It would help me more-- maybe this is just completely out of the range of the case, but the more I sit here, the more interested I am in the characteristics of real live methadone patients.

You talked about the prototype. That was very helpful. I guess there are other prototypes we can go into.

THE WITNESS: Yes, sir.

THE COURT: But at least we get to some idea of these people as real human beings.

What it would, as I sit here, what it would help me to do is to get actual, some kind of profiles, the methadone patients, prototypes, whatever you want to call them, find out about, are these-- is such and such a prototype a rare -- you know, is he the vice president of the bank who suddenly got on methadone -- I mean heroin, and he is-- or is he some one percent minority or is he typical. That kind of thing. But take examples of real methadone patients and then juxtapose those against the jobs in the Transit Authority.

That would be the kind of mental process that you would go through, right?

THE WITNESS: Right.

THE COURT: If you were doing the work you offered, if the Transit Authority ever undertook to hire these people or consider then, that's the process they would go through, right?

THE WITNESS: Yes, sir.

THE COURT: And maybe something like that could be done. We have had a lot of theory in the abstract, a lot of medical theory and so forth.

How much more of that will help I don't know.

MR. DUNN: I have a substantial amount of questioning remaining based on what the doctor testified to on direct examination.

THE COURT: On what subjects? Let's see whether it is really going to be worthwhile.

MR. DUNN: One is the identification of the programs that Dr. Dole works with.

THE COURT: The identification of the programs?

MR. DUNN: Yes. Dr. Dole talked in the first person singular. We do this, we do that. I would like to have identified who Dr. Dole was referring to when he used the term "we."

THE COURT: I thought that was pretty plain. He is talking about Rockefeller Institute, Rockefeller University sometimes.

Q Are you confining your remarks to Rockefeller University methadone program, Doctor?

A No. Not in all answers. I think you have to interpret it in relation to the question you asked. Maybe you would make it specific.

THE COURT: He referred numerous times to numerous different entities.' Sometimes to Rockefeller. Sometimes to Dr. So-and-So's committee at Rockefeller and sometimes to Beth Israel, sometimes to the City of New York.

Are we going to go back and ask him what he was referring to? I thought it was perfectly plain.

MR. DUNN: It is not clear to me, your Honor, with all due respoect.

Q When you refer to Rockefeller University's methadone program, how many patients are there in the program,

Doctor?

A At the present time, the research clinic has only about twenty patients there.

But that is certainly not the limits of my information.

Q What other programs do you work with or for or do you supervise?

A I operate through my department, the principal responsibility for the methadone data center which maintains the computerized inventory on all 40,000 patients in treatment and I have reports sent to this center from all the regions of Metropolitan New York on the methadone patients.

Q Do all programs report, Doctor?

A Yes, sir.

Q Every methadone program in the City reports?

A Yes, sir. All of them. All of the known programs report, I presume.

Q You said, did you not, that all of the programs are based upon your model?

A Yes, they are all derivative on it. Obviously they find their own style and particulars.

Q Does your model have as a goal detoxification?

A As I mentioned before, that is not the primary goal. It is a desirable attainment but the goal of our programs is normal social function.

Q Are you familiar with the New York Medical College Methadone Maintenance Program?

A Yes, sir.

Q How, if at all, does it differ from your model?

A It is not strictly a methadone program in the sense of our model. It is a research program in which people are given various drugs in various doses. Its patients are known but -- to the registry and to the general information, but its function is a very specialized research unit.

Q Is that a program that reports to your data bank, Doctor?

A Yes, I believe we have data on that. The names of the patients. My data bank is primarily a registry of patients.

Q You stated that you could judge to some extent, as I recall it, you could judge the program's ability or the program's success with the data you have accumulated in your data bank.

A Yes, we have various measures of it. The most detailed documentation comes from the major public, the supported programs such as Beth Israel, the City Health

Department programs, Bronx State and a collection of smaller programs in voluntary hospitals such as Mt. Sinai and Van Epton and so on.

In total these ones of which we get detailed information comprise about 25,000 out of the 40,000.

Now, in addition to that, we have simply registry information to know the existence of the others. We have supplementary information because all the correctional facilities are tied into my data bank and anybody who is recognized as a methadone patient in the correctional facilities are reported in my data bank, so we have a direct tally of the people who get arrested regardless of any other reporting.

Q Does the Samaritan Halfway House report to your program?

A I have to look it up to see. I am afraid I don't have the listing of the 150-odd clinics.

Q Are you familiar with the Samaritan Halfway House?

A I have heard the name.

Q It is in the methadone program?

A I say, I would have to refresh my-- at least I have to look it up. I don't know.

Q Does SERA report to your data bank?

A Yes.

THE COURT: We cannot go through every program.

MR. DUNN: I am only going through four.

THE WITNESS: SERA program up in the Bronx. It is not strictly a methadone program. It is one of the so-called methadone-to-abstinence program. It is not a methadone program inthe sense that we have defined it.

We do,however, get a listing of just the patient's entries into our data system.

Q Isn't Samaritan Halfway House, the Lower East Side Methadone Program, SERA, New York Medical College and four clinics at Kings County a methadone-to-absinence program?

A You are probably right.

Q How do they differ from the programs you have been describing?

A Their goal is to detoxify. The theory there is that methadone is a way to engage people in treatment and once you have them in treatment, now you, through group therapy and various other processes, persuade them that they can live without drugs and then at the very earliest opportunity, you detoxify them.

This is a theory that's to be tested. It is not the methadone program I have been describing.

Q It has no bearing on your model?

A I would say it is the denial of my model because the theory there is that the person hasn't accomplished anything until he is detoxified.

On the contrary, our model emphasizes the importance of a man's normal social function. That is the goal. Not detoxification.

Q You say his normal function, Doctor.

You are saying normal function while taking a specific dosage of methadone, are you not?

A I am saying normal function, period. Because many of our patients do detoxify and do it very well and we are certainly pleased about it. We are not linking normal functioning to the taking of methadone. What we are saying is that the goal is normal functioning. The goal is not detoxification.

Q But we are sure that every person presents a problem with respect to every day of his life. With respect to the Methadone patient, the problem is presented when the person is on a constant dosage.

Are these problems at all increased or are additional problems present when you increase the dosage of Methadone or when you take a detoxification course and go below twenty milligrams of Methadone daily? Are there additional problems?

A I would say that the change of dosage within moderate limits doesn't make any difference, but when you detoxify a person, if he subsequent to detoxification is in an irritable state, he is obviously less patient. It isn't that you created new problems, but you affected a person's patience to deal with problems that come upon him.

Q So that a person may, according to what you have said, Doctor, be stabilized on Methadone and at a particular point in time, in treatment on a high dosage of Methadone, in your opinion might be qualified for particular employment?

A There is no doubt.

Q Would that not be true?

A Yes, sir.

Q If during the course of this treatment a decision is made to detoxify the individual, may there not come a point in time where this person, as a result of the detoxification course or as a result of having been detoxified, will be unemployable? May this not occur?

A Yes. You could certainly discover an example where it could occur. I would think it was not the norm. We have many patience who have been maintained for long periods of time, who then have been detoxified and doing very well.

The point is, as we discussed earlier, judgments have to be made on an individual basis. You cannot rubber-stamp a policy that applies to everybody.

Q Are you suggesting, Doctor, that patients enrolled in Methadone programs that follow your model can be reasonably expected to remain in those programs the rest of their lives?

A No; not necessarily. I would like it to be felt that that was a medical decision, and I would hate to have it so that any legal process or any pressure from public opinion would govern the medical handling of it. I would like to feel that if it is considered medically desirable to continue a person, that the option is there, but the proper medical procedure is to go step by step, and if a decision is made that the time has come to detoxify, to do it with understanding, under medical control, and if there is any problem, if the person feels restless or irritable or dysphoric and exhibits symptoms of being uncomfortable, that there is no embarrassment or problem, just to move back into some program of Methadone.

So if done under proper management, I don't see any hazard at all, either to the person, the job or the clinic.

Q Doctor, how do you recognize that detoxification is not working properly?

A Well, I would say it is in terms of the patient's symptoms.

Q What would these symptoms be, Doctor?

A Mostly irritability, insomnia and a sense of restlessness.

Q You described one characteristic as being symptomatic in your 1974 article, that is, poor performance on the job.

A Yes. If somebody cut a person off in what I would regard as a very bad business, somebody who was doing well on a Methadone program now under a lot of pressure from public opinion.

Q You weren't talking about that person in the 1974 article. You were talking about the person apparently successful in a program, as I understood it, and then was detoxified.

A Right. If a person is detoxified and doing poorly, it is very easy to come back on a dosage of Methadone, providing he has not been pushed off in such a way that he is deprived of his return.

Q But it is reasonable for the employer to believe that one of the symptomatic conditions will be poor performance on the job during that period, would it not, Doctor?

A It may or may not be. It depends on what kind of a job. If a man gets irritable enough, he might quit the job, that sort of thing. But I have never seen it translated in terms of, let's say, poor judgment on a judgment, that type of thing. He may just not want the frustrations any more of the job, that type of reaction.

Q Were you a participant in or did you attend the Fourth Annual Methadone Conference, Doctor?

A Yes.

Q Are you familiar with a paper that had been submitted by Dr. James F. Maddox, entitled "Methadone and Medical Ethics"?

A I recall it was given, but I didn't attend it. I should explain, perhaps, that this conference had some three thousand people at it, and it was broken up into a great number, a dozen or so simultaneous sessions around, so I really can't comment on the paper until I have a chance to read it.

Q Are you familiar with Dr. Maddox?

A I know the name. I have never met the gentleman.

Q He is a psychiatrist in the Department of Psychiatry at the University of Texas Medical School, San Antonio, is he not?

A I will accept your word for it.

Q Do you recognize him as an expert in drug addiction?

A Well, I don't know how you define the "expert".

Q Is he a person who is learned in the field?

MR. BALBER: Your Honor, the witness testified he barely knows this person.

Q In the paper I referred to, Dr. Maddox said that regularly administered Methadone, like morphine, probably produced profound and long-lasting changes in physiological and psychological equilibrium. "Quite possibly these changes become more severe and deeply embedded with continued daily high-dose Methadone. For the individual with hope of overcoming his drug dependence, Methadone maintenance may reduce the possibility of his achieving an enduring abstinence."

Would you agree or disagree with Dr. Maddox?

A Disagree.

Q On what basis do you disagree?

A Forty thousand patients.

Q Can you be more specific than that?

A Yes, sir. We have been following Methadone patients for ten years. We have a volume of documentation on these patients that far exceeds any information that Dr. Maddox has. What grounds he has for making the statement I have no idea.

Q What percentage of your patients have successfully detoxified and remained drug free for a period of one year, Doctor?

A I think we ought to return to the discussion about what the goal of our treatment is.

Q I am asking you a specific question.

A I do not have an answer.

THE COURT: Didn't you say there are statistical studies now going on that had not been completed?

THE WINTESS: Yes, sir. We are following up the status of people who have been in treatment and who have left it, and we do not have the data on that point.

THE COURT: It is a quarter of six.

I think that the testimony has been extremely helpful, and I don't want to prevent you from any legitimate cross-examination, but we do have to face the problem that the end of the day has come.

CURRICULUM VITAE

HARVEY GOLLANCE, M.D.

Born: New York City
July 1, 1910
Married - 4 children

Education and Experience:

1972 - Present - Director, Morris J. Bernstein Institute of Beth Israel Medical Center, New York City.

1969 - Present - Associate Director, Beth Israel Medical Center, New York City (In Charge of Narcotic Programs and the Methadone Maintenance Treatment Program).

1964 - 1969 - Deputy Commissioner for Operations, Department of Hospitals, New York City (In Charge of Operations of 19 municipal hospitals, including Bellevue, Kings County, etc.).

1961 - 1964 - General Medical Superintendent, Executive Assistant Commissioner Department of Hospitals, New York City.

1957 - 1961 - Supervising Medical Superintendent, Kings County Hospital Center (at that time, 3,100 beds with a large general hospital, psychiatric hospital, and tuberculosis hospital).

1950 - 1957 - Medical Superintendent, Coney Island Hospital.

1941 - 1950 - Deputy Medical Superintendent, Kings County Hospital Center.

1937 - 1941 - Director O.P.D., Morrisania City Hospital.

1936 - 1937 - Physician, Morrisania City Hospital.

Education and Experience: (Continued)

1934 - 1936	-	Intern and House Physician (Medicine), Morrisania City Hospital.
1934	-	M.D. - New York Medical College.
1931	-	B.S. - College of the City of New York.

Organizations:

Fellow, American College Hospital Administrators.

Fellow, American Public Health Association.

Lecturer, Columbia University School of Public Health.

Lecturer, Downstate Medical College, State University of New York.

Associate, Mount Sinai Medical School.

Former Member, Executive Faculty Council, Downstate Medical College, State University of New York.

Teaching programs on Drug Addiction and Methadone to medical students from Columbia University, Cornell Medical College, and other local medical schools.

Representative of Health Services Administration for Narcotics.

Participant in various workshops sponsored by the National Research Council.

Member, Narcotics Register Advisory Committee, New York City Health Department.

Member, Methadone Evaluation Committee, Columbia University School of Public Health and Administrative Medicine.

Carl A. Beazer, et al

riesa

v. 72 Civ. 5307

New York City Transit
Authority

January 9, 1975
10:20 a.m.

(Trial resumed.)

* * *

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HARVEY GOLLANCE, called as a witness by Plaintiffs, being first duly sworn, testified as follows:

THE COURT: Dr. Gollance, is it Gollance?

THE WITNESS: Yes.

THE COURT: I want to tell you something you are probably aware of already, but you are here really not as a witness for the plaintiffs or the defendants.

At a prior stage in the trial I discussed with counsel my need in order to decide this case for further expert testimony, further testimony about the methadone field and the clinics and so forth.

It began to appear that some people were reluctant to come to testify because they were concerned about becoming partisans in a partisan struggle and then since they were reluctant, nobody really wanted to subpoena them, so I intervened and really, we have two vigorous points of view here, but really, everybody here is trying to look at this thing as objectively as possible and in the broad interests involved, so we needed witnesses to assist us all in that.

So I can assure you that that's really the frame - work you are being adked to testify in.

Both sides will be asking you questions and maybe one side has interviewed you, I don't know, I'm not concerned with that.

The plaintiff's lawyer, Mr. Balber, will lead off. I will ask some questions, the defendants will ask questions.

Okay.

DIRECT EXAMINATION

BY MR. BALBER:

MR. BALBER: Your Honor, I asked Dr. Gollance to bring a copy of his curriculum vitae.

If there are no objections, I would like to have it marked for identification and received into evidence.

MR. DUNN: May we have a copy of that?

x (Plaintiff's Exhibit 49 marked for identification.)

MR. BALBER: Is that recieved, your Honor?

THE COURT: Yes.

x (Plaintiff's Exhibit 49 received in evidence.)

BY MR. BALBER:

Q Dr. Gollance, your vitae states that you are Director of the Bernstein Institute and Associate Director of the Beth Israel Medical Center.

Can you describe what your responsibilities are in those positions?

A Yes. The Bernstein Institute is one of the units of the Beth Israel Medical Center. It has approximately 350 beds primarily devoted to the treatment of addictive diseases, that is, alcoholism, drug addiction, the medical complications of addiction and we also have a regular psychiatric unit.

In addition, we have a very large methadone maintenance treatment program involving 14 hospitals and I guess about 35 clinics and I'm responsible administratively for these programs.

THE COURT: Let me get -- the Bernstein Institute has an in-pagient facility, 300 beds--

THE WITNESS: 350 beds, your Honor.

BY THE COURT:

Q For all types of addiction?

A That's right. Alcoholism and drug addiction, yes.

Q And then is the methadone maintenance program under the Bernstein Institute?

A It is under me. It is a sort of dual responsibility. I have Bernstein Institute and then I have the methadone maintenance treatment programs with a separate staff.

Q You are head of the Beth Israel methadone--

A I am head of both, the Bernstein Institute and the methadone.

Q You are head of the methadone?

A I am the administrative head of that.

Q For Beth Israel?

A That's right.

Q And that has how many separate facilities?

A Your Honor, approximately 35 clinics. And we are associated with 14 hospitals.

THE COURT: Go ahead.

BY MR. BALBER:

Q Since Dr. Trigg will testify later in this case, can you explain the division of responsibilities between you and him?

A Dr. Trigg is my associate director for the Bernstein Institute but he is also the clinical director of the drug programs, and he is a man who has had broad experience in this field.

Q Dr. Gollance, are you familiar with the arrangements that the methadone program that you head has established to assist employers in assessing the job suitability of your program and patients?

A I can touch briefly. The objective of the methadone maintenance program is to rehabilitate the patient, it is not just to take care of his drug hunger, so a prime function is to get jobs for the patients and we have people who devote practically their full time to opening job opportunities for our patients and to help our patients get the necessary training or whatever is needed so they can work.

Q Can you describe, then, what information about patients your staff provides to employers as part of their assistance to those employers when they are trying to place patients?

A We will try to work closely with the companies that want that, always, of course, with the consent of the patient. We will never give out any information that the patient doesn't fully agree to so we will try to work and give our assessment of the patient if they want to, and we have a group of large companies that we finally have opened up and we work with either their medical director or personnel director or both.

Q This information that you provide, does it include a physician's evaluation?

A It usually has a three-part component. The physician gives his evaluation; the patient's counselor will give his evaluation, and our vocational counselor will give an evaluation.

BY THE COURT:

Q Go over that again.

Whose evaluation?

A The first one is the physician in charge of the patient and he will give the medical evaluation and his general outline.

BY MR. BALBER:

Q Is that usually the clinical director?

A The unit director. The one in charge of that particular clinic. All our clinics ar directed by physicians. And he will give his evaluation.

The counselor assigned to the patient, who has been working with the patient will give his evaluation and we have a special unit for vocational rehabilitation counselors and they will give their evaluation.

THE COURT: What do you call the third--

THE WITNESS: The vocational rehabilitation counselor.

They are people who have had special training in this field.

tlb am

Q Do they work under Miss Wolkstein? She testified previously.

A Yes, she is in charge of our vocational rehabilitation program.

Q What is included in these evaluations, do they include the patient's prior employment history?

A Yes, they do. They include -- for example, a physician will give his evaluation of the patient, that he has been coming regular, he is not abusing drugs, that he has been cooperative in all these ways and in his opinion the man is in physically good shape to do this work. All the things a physician might look for that would have some bearing.

Q Would he analyze the patient's family situation for example?

A We go into all that. Usually the counselor will do that.

Q His emotional stability?

A That will be assessed usually by the physician. Or by the counsellor, either one.

Q Will there be reports if he has been having legal problems?

A That would be in the record, surely.

Q Did you say drug abuse?

A Yes, we look for any evidence of drug abuse.

Q Now, Doctor, I believe you said a moment ago that you established relationships with a number of companies where you provided this type of referral service. Can you name some of these companies?

A Well, we have several insurance companies, some of the large insurance companies. We have some of our patients in Con Edison. We have just finally opened up the New York Telephone Company, have gotten our first patient there.

THE COURT: How many do you have at the New York Telephone Company?

THE WITNESS: I say we just got our first patient in there. This was a most difficult job. I had spoken to the medical directors of the phone company and the personnel directors. I must say it takes a lot of doing until they finally do it but I may say we keep a close record on what has happened and they have turned out -- here, J.C. Penney, Segrams, Met Life, New York Life, Equitable Life, Rockefeller Center. Con Edison.

THE COURT: Just a little slower.

THE WITNESS: Con Edison.

I think you know recently the post office has opened up to our patients.

Q You said you keep track of these patients?

A Oh, yes. One of the interesting things about this program, I don't know if I have the time to give you some background. I think it might be useful. We have this terrible problem of drug addiction in New York City, now over 25 years. I was head of the largest hospital in New York City, Kings County Hospital. Then I became Deputy Commissioner of Hospitals in charge of the operations of all the municipal hospitals. We set up a number of drug programs and they were very unsuccessful and then Dole a Nyswander came along with the methadone program.

One of the things they did when they established it -- go back a little. Dr. Trussell, formerly Commissioner of Hospitals in New York City and is now head of Beth Israel. When Dole came to him with his protocol, wanting to expand it, Trussell, as Commissioner of Hospitals, got him the means to expand it.

One of the things that was done was a separate contract was given for an independent evaluation by the Columbia University School of Public Health, not done by us by done by them to see what happens to our patients, so this is about the only drug program I know of that has records on every single patient that has ever come into the program.

We know who is in the program, who dropped out, who is abusing drugs, who has been arrested, who is working, who is on welfare, who is off welfare, things like that.

And so we watch very closely what happens to our patient.

THE COURT: Are there some records --

THE WITNESS: I think Dr. Francis Gearing puts out reports of what has happened to the methadone patients from the Columbia School of Public Health and they include our patients.

MR. BALBER: Your Honor, the written statement that was introduced when Dr. Gearing was on the stand is one such report. Instead of introducing all of them it was one of the more recent reports we thought was fairly comprehensive in nature.

THE WITNESS: I point out for general interest that a great many of our patients hold very productive jobs. We have one clinic, for example, where over 90 per cent are working and as we say, they have become taxpayers instead of tax users. Our experience has been when they come to us, a very high percentage are on welfare and as they stay with us, welfare goes down and employment goes up. And the same thing with their criminal records. This is one of the things that is looked at and the

Columbia study is a very interesting one, I think. They took a group of patients in the methadone program and they tracked back their arrests and convictions prior to entering the program. They went back three years. And it showed this group on the whole had 120 arrests per hundred patients per year and 48 convictions per hundred per year. Then they followed them for four years in the methadone program and the 120 arrests per hundred dropped to 4.5 per hundred and the convictions dropped from 48 per hundred to 1 per hundred. And I think this shows that the addict basically is not a criminal. His criminal behavior is due to his need to get the large sums of money he needs to maintain the heroin habit so we take away the need to do that and we can begin to work with him and again, I will stress, the methadone does only one thing. It makes the patient receptive to rehabilitation. Something that we haven't been able to do with this group of patients before.

THE COURT: The thing is that we are slowly getting a better idea in this case of what is meant by rehabilitation and what it is that needs to be rehabilitated. The case pretty well started out with the basic physical problems, which are obviously important. Psycho-motor tests and those things that are administered by doctors.

Then it is becoming very, very clear to me, I am sure it was to everybody else before me, that -- what you are saying now. It isn't just a matter of giving a fellow a dose of liquid in the morning but we keep asking and maybe you can give us an idea and I don't want to interrupt the fellow but at some point I want to get all the information I can but what it is that needs to be rehabiliteated and what you do and how long it takes and so forth.

THE WITNESS: There is no --

THE COURT: I am sure it varies. You got different categories of people.

THE WITNESS: Exactly. We do an individual assessment of the patient and try to meet those needs.

For example, we did a study some time ago and at that time we found that we could take about a third of the people who came into us and with very little more than the methoadone, they were able to go out and hold jobs and have jobs. Once we took care of that --

THE COURT: What kind of people are those?

THE WITNESS: The addict is a whole rang of individuals.

THE COURT: You found that a third of the people -- if you could satisfy that drug need --

THE WITNESS: Then they went out and they held jobs.

THE COURT: They would need --

THE WITNESS: They would need less. A third of them needed a moderate amount, where the staff would have to give a moderate amount of time. Then there would be a third that would need a great deal.

THE COURT: When you are giving me these figures of a third and so forth, you are talking a third of what?

THE WITNESS: Of the patients coming into us, into that group.

THE COURT: Of the Beth Israel?

THE WITNESS: Yes.

THE COURT: Of the whole Beth Israel operation?

THE WITNESS: No, in that particular study.

THE COURT: What was that study?

THE WITNESS: It was a study of a group of patients to see how they would do if they got minimal supporting service.

THE COURT: Is this written up?

THE WITNESS: I will have to check that.

THE COURT: What was the kind of population that you drew from from this study?

THE WITNESS: WE have a -- it is a very mixed population. The addict population in New York City --

THE COURT: For this study did you take one kind of person?

THE WITNESS: No, this was as they came into this particular group. They were not selected specifically.

THE COURT: You found --

THE WITNESS: It would be a random admission.

THE COURT: How many people were involved in that study?

THE WITNESS: There were about 100.

THE COURT: You say about 30 or so of them really didn't need any rehabilitation at all?

THE WITNESS: That is right, a minimum amount.

THE COURT: All right. Would you be able to tell me what kind of people they were?

THE WITNESS: I know what you are getting at. This is a surprise. This was a surprise to me. I think the rest of our staff will verify this. It is very hard to evaluate the individual when he first comes in. You have to watch him for a while. People who look as though they are well put together turn out not to be, others who look pretty beat up turn out to do well.

We have to keep an open mind on that.

THE COURT: All right.

Just looking at narcotics cases from the standpoint of sentencing, I see all kinds of people. There is the college student who has gotten involved and then there is the ghetto fellow --

THE WITNESS: Yes.

THE COURT: -- you know.

THE WITNESS: Yes.

THE COURT: What I am going to wonder more and more in this case, is the people that seem to do well in employment, are they really drawn from a small minority of the patients or do they indeed represent a fairly broad cross section? Thatis why I am interested in your study when you say --

THE WITNESS: I would say they represent a broad study. For example, the patients in Harlem did well and the patients in white communities did well. Their problems were different, though.

As you point out, the black was started in his adolescence. He did it because all the kids were doing it.

It is a different proposition from the schizophrenic, you know, the white schizophrenic who didn't have the need that the black had. He had psychiatric difficulties. He goes out and gets on drugs and he is a different problem from the black.

In general, we have white who do well, we have blacks who do well, we have Puerto Ricans who do well.

I don't think you can generalize.

THE COURT: I am not trying to.

THE WITNESS: Thatis my feeling.

The same thing is, we hear addict personality. Our feeling is, there is no addict personality. We see a wide range from people who are well put together to some who are badly psychotic. They go the whoel range of the general population.

THE COURT: Just take it very slowly. This study that you had, I wonder if that is written up.

A I have to go back. I know the staff has had discussions on it. That was the sought of conclusion they reached at that time.

THE COURT: All right.

Let us take for just a moment and see -- maybe you don't remember. I wouldn't expect you to.

The third that didn't need much rehabilitation, can you give me any idea of the kinds of people that were involved and then what kinds of jobs they went out to? Do you have any idea?

THE WITNESS: I would have to go back on that.

THE COURT: All right.

THE WITNESS: I would have to go back on that.

THE COURT: All right.

Okay, Mr. Balber.

BY MR. BALBER:

Q Dr. Gollance, from this study and from your other experience, can you give the court some indication of what criteria, what characteristics in a patient's background are predictive of good job reliability or rehabiliation? What factors would you look at if you were evaluating a patient and trying to tell an employer whether or not he would be a good empooyment risk?

A Let me answer that in a larger general way. You know, when we have the black population, they will go out and take the poorer paying jobs. In our Harlem clinics, for a while they had the best employment records. They would go out and take a job as an elevator operator. Very often if you got the white middle class person, he wanted a better type of job. So his job expectations might not have been as realistic as the black. These are generalizations. We have seen all changes.

The important thing I think is to take the individual and have the staff see him, work with him and assess him. The potential exists among all the groups. You just can't say that this group had a poor record and this one had a good record.

In some cases the whites have a better chance of getting jobs because they have an uncle who has a business or they have a relative who can help them. But in general you can pretty much tell about the patient after you have had him a few months what you have got and what you can do with him. That is what we try to do.

THE COURT: Out of the 40,000 -- let us start on another angle.

Are there about 6500 in the Beth Israel?

THE WITNESS: Yes.

THE COURT: Would you be able to tell me how many of those are employed?

THE WITNESS: Well, I would check that. I can give you the range.

As I say, in one of our clinics we have as many as 90 per cent employed. We have others where there are new patients coming in, where perhaps 40 per cent are employed and the whole rang in between.

On the whole it used to be after wehad them, and Gearing's report showed that, we ould have about 70 per cent of our patients employed.

THE COURT: After a certain period of time?

THE WITNESS: Yes. There is an economic factor that comes in, it shouldn't, but it does.

If you take a man on welfare, he is entitled to Medicaid reimbursement. So you have no trouble financing your program when you take that type of patient.

When youget the fellow who can't pay, then you have a problem.

That has some bearing on certain intakes of programs.

THE COURT: What is the exhibit number for Dr. Gearing?

MR. MORRILL: Exhibit 45, your Honor.

THE COURT: 45?

MR. MORRILL: Yes, your Honor.

BY MR. BALBER:

Q Dr. Gollance, do you know what professions some of your patients occupy?

A Yes. There is a wide range.

Q Can you name some, the specific jobs they do?

A Well, we have one -- let me say the way I get it.

Under the federal regulations a patient has to come into the clinic a minimum of twice a week unless you get an exemption. All exemptions from these regulations pass across my desk. The usual reason for an exemption is because of the type of job the man has.

For example, I had one not so long ago, the man was a computer expert. He had to travel around the country setting up programs. Others are truck drivers who go out on routes that keep them away for at least a week. This is verified by their employer and who have very good work records.

We have men who started in New York City and then as they got rehabilitated they moved out and established small businesses.

For example, I had a request on my desk from a man who set up a trucking business one hundred miles from our clinic and he had bought the truck with payments due. He bought a house up there. He had gotten married. He pointed out if he came down to us twice a week, he lost two days a week and he couldn't afford to lose that. He said he would be in danger of losing his business.

From everything we hear, he runs this, he does very well at it.

We have men who drive heavy trucks, fuel oil trucks, things like that, who may go out on routes or have a time schedule. One week they may have to work peculiar hours that make it difficult for them to get into the clinic on time. As one man wrote -- this was verified -- he has to stay on the job until it is true. This may involve overtime. He just can't say to the employer, look, I have to get to the clinic, you get somebody else. In cases like that we write for exemptions.

I see a wide range of job categories that come across my desk. I have one that came right in yesterday. This man is the manager of a shop that does floral decorations for various kinds of exhibits and he travels around the country. Now they had a job out of New York City that he would have to be away from for at least a week. Things like that.

They hold all categories of jobs. Some of them do very well financially.

As I say, we have to evaluate them. There are others who cannot hold jobs. We get patients who have many other problems other than their drug addiction. Even if they didn't have that, they couldn't be able to hold jobs.

We do -- we have to evaluate the individual.

We see all kinds of skills and all kinds of capabilities if they are given the chance.

Q Dr. Gollance, do you know what proportion of the people in your methadone program are employed at the time they enter the program?

A I would say roughly about 30% of any kind of legitimate job.

It is changing somewhat, I think, for a particular reason in that we see individuals now who are working but have gotten their methadone not through clinic sources, so they are able to hold their job.

As I say, you have to keep evaluating what is happening. This is not a rigid, fixed picture; it changes.

In the beginning we were very, very restrictive of the type of individual we took in the program. He had to be basically just a heroin user and have no other problems. If he was a -- any story of alcoholism, we wouldn't take him. If he used any drugs, we wouldn't take him. If he had any psychiatric history of any kind, we wouldn't take him.

It was a new program. We wanted to watch to see what would happen. If you take that group, the results were just beautiful.

As time goes on, we got more comfortable with it and so we take in individuals and assess their capabilities. That's what we try to do all the time.

THE COURT: You take in different individuals now with additional problems that you wouldn't take in then?

THE WITNESS: For example, if they had any medical problem we wouldn't take them in. For example, a man was a diabetic or had any pronounced liver disease or things like that. Then we found out that methadone used properly is an extremely safe drug. So we no longer have any medical exclusions.

We would take that individual in and get him the medical care he needs.

As a matter of fact, we established a 45-bed unit in Bernstein Isitute for the medical complications that an addict might have.

We get addicts of all ages. We have them in our program up in their eighties. So they will get sick from various things. We provide the medical care for them.

Q Dr. Gollance, have you ever had the occasion to meet profesionally with officials associated with the Transit Authority?

A Yes, I saw you the other day and I looked through my book. I had a recollection of it. In December of 1970 -- I don't know what initiated this, but Dr. Lancetta from the Transit Authority came down to look at our programs at Bernstein Institute.

THE COURT: When did he do that?

THE WITNESS: December of 1970.

Subsequently I was invited to talk to some of the supervisors at the Transit Authority headquarters. I think it is on Jay Street. They set up a meeting where I could discuss it with them.

Q If we can go back to that first meeting, December 170 meeting, for a minute.

Can you describe what was discussed at that meeting?

A Well, it is quite a while ago. My impression at that time is that they really did not know the methadone program, that there are a lot of misconceptions and a lot of -- I guess you would call it hearsay and fairy tales.

We try to show them, you know, what we considered a decent program and what we were trying to do.

Q Did you explain to him the pharmacology of methadone?

A Yes, I'm sure we did.

Q Did you explain your counselling program?

A I'm sure we did.

Q Did you explain your therapeutic approach?

A I'm sure we did because I do that with anybody who comes in. As I say, I don't remember the exact specifics, but if I had anybody down there, I would -- I would try very hard to tell them what we are attempting to do and how we do it, what we think the good points are, what we think the shortcomings are, things like that.

Q Did you state at this meeting that in your opinion some of your patients were suitable for Transit Authority employment?

A Yes. I remember one thing we always kept running against, you know. "Would you let him be a motorman?"

I pointed out that, "Look, there are a lot of jobs in the Transit Authority that are not motormen. There are people who sweep the stations, we have people working in the OTB who have done extremely well, who could handle the change booth, who could do almost any of the things, could do maintenance work.

If they were suitable and their work record was so and they met the qualifications that anybody else would meet, I didn't see why they couldn't be a motorman.

Of course, what came out, what was really worrying them, and I can see why, if there should be an accident and they had this history, you know, they might have difficulty explaining it.

I think if you select them properly, and we think that is not hard to do, there's no reason why they couldn't perform any job.

THE COURT: Yousay it is not hard to do. I think that's a subtle point, but it is something that I really need to know more about.

Dr. Dole was here the day before yesterday and indicated -- at least I drew the impression -- that it might be a very hard judgment to make if you had a man who had been a heroin addict for five or ten years and then he's come into a methadone program and say he's been on the methadone program six or eight months -- his employability might require a judgment beyond the ability of the normal personnel officer of the Transit Authority.

THE WITNESS: Well, I would believe six, eight months is short.

THE COURT: All right.

Getting at this, that the Transit Authority personnel would need this very special expert judgment of the supervisors at the methadone clinic in order to make a sensible judgment, would you agree with that?

THE WITNESS: Probably.

THE COURT: Why --

THE WITNESS: But I think that can be done --

THE COURT: Okay.

What are the factors that give it any degree of difficulty in determining whether somebody should be employed who is on methadone?

THE WITNESS: I don't think it is any more difficult to make a determination -- what do you do with an alcoholic, a man has an alcoholic history --

THE COURT: Let's not start with the alcohol.

THE WITNESS: I will leave it that way, okay.

We feel that we get to know these people quite well. You know that they are not abusing drugs, you know what their attendance record is. We have patients in jobs doing heavy work who have not missed a day in -- since they have been working there practically.

Their whole behavior is consistent with what you would expect of a responsible employee.

THE COURT: When you hire somebody, you are having to make kind of a prediction. You don't know about his record before he has had it, right?

THE WITENSS: Well, we would know something about his record.

THE COURT: The man who is hiring has to try to make a judgment about what will happen in the future, right?

THE WITNESS: Yes.

THE COURT: Okay. That's obvious.

Just look at it in the most objective way you possibly can and give me the problems that you would have to think about if you were the fellow who was worrying about it from the standpoint of the Transit Authority.

You are not the fellow trying to get him rehabilitated and promote his welfare. You are on the other side of the picture and you are worried about whether he is going to do a good job.

What are the problems you have to think about?

THE WITNESS: There are very non-sensitive jobs, I'm sure, in the Transit Authority.

Before a man would be given any position of responsibility, he would have to go up there, he would be under the observation of his supervisors, he would be under the observation of the staffs in the clinic that's examining him, he would be under the observation of their own medical department.

THE COURT: Just give me an idea of the problems that you would conscientiously be concerned about if you were looking at it from the standpoint of the

Transit Authority.

What are the problems that you would want to be alerted to?

THE WITNESS: You would want to know whether he's reliable in his work record, that his behavior both outside and inside his job is proper, that he could meet any test that you require of anybody else for a job, and generally the observation of his-- of the people watching him.

Just to give you an example, we use a limited number of patients in our program.

Before we put them directly in our program they must go out and hold a job for a year on the outside. Usually they are very non-sensitive jobs. For example, they may work in the hospitals as a messenger or they may run an elevator or something like that.

Then you see that they come in regularly, they have not had any trouble, the clinics report that the man is doing well from everything they can see and then you will promote him into a job which is basically -- we use him in a counselling capacity. You watch him again. If he's done a very good job as a counselor, everybody is satisfied.

We may make him a supervisor of a clinic. Again, you watch his work record, how he is doing in the clinic.

If you think he has the capability, you make him an assistant administrator. That's what we have done.

I don't see why, you know, big employers can't do something similar to that.

You are not going to make him a high level employee right off the bat. He can go to various levels.

THE COURT: Why is it that, say, the New York Telephone Company has been persuaded to hire one man?

THE WITNESS: Because there is a lot of, there is a very emotional tone around this thing. When you say "drug addict," you know, people really get uptight and they have a hard time evaluating.

As you know, everybody knows, there is a lot of things said in this area without careful evaluation and eventually we talk to the people in the medical department and eventually we have to get to personnel.

Just to give an exaple in one of the big companies I went to, I spoke to the medical department and they said,"Well, we are not opposed to it if personnel will hire them."

And then you go to personnel and they say, "Well, we are not really against them but the man lied when he applied to us. He didn't tell us he was a drug addict."

So you find all this kicking around until you finally get them to agree that they will try a limited number and see how they do.

And that's been our experience in the past. They agree to take a few people who everybody cleared and they do very well and they take a few more and that helps.

THE COURT: Is there one man that's being hired by New York Telephone?

THE WITNESS: I was told that yesterday. I checked with--

THE COURT: You say they are cleared.

What are the criteria--

THE WITNESS: That they accepted?

THE COURT: Yes.

THE WITNESS: I don't know the history of this particular man but I know he has been clared by the physician, by the counselor, by the vocational guidance people.

They consider that he can do this work.

THE COURT: Did New York Telephone-- did New York Telephone give you any set criterion like he has to have certain attributes or are they pretty flexible?

THE WITNESS: I can't answer that right now. As a matter of fact, I only heard about this yesterday so I will go back and re-check that.

THE COURT: Okay.

BY MR. BALBER:

Q Doctor, when you said there was one patient working for New York Telephone, you meant from your program?

A Yes. From our program.

Q Do you know if he is the only methadone patient working for the New York Telephone Company?

A No, I don't.

Q After that first meeting you described with the Transit Authority officials, you mentioned you had a second meeting.

When did that meeting--

A My recollection is I was invited down to speak to this group of supervisors and I don't remember but it must have been some time in 1971.

Q Do you recall who was included in that group of supervisors?

A No, I don't.

Q Wouldit refresh your recollection if I were to ask you if a gentleman by the name of Mr. McLaren is one of those persons?

A Somewhere along the line I know I did meet with Mr. McLaren. I believe he had something to do with it but, as I say, I talked to so many people, so many groups.

Q Was there someone at this meeting who was identified as the Director of Personnel?

A I'm not sure.

Q To the extent you can recall, can you explain what was discussed at this second meeting?

A Just - I tried to explain the program, what we do, what our experience has been, how it's done, and try to answer any questions that are raised.

Q During --

A It is basically an educational meeting in which we hope to have the opportunity to present what we think we are doing and how we see it.

Q Did you offer to cooperate with the Transit Authority in screening your patients who were applying for Transit Authority jobs?

A I'm sure we would do that. As a matter of fact, I recommended to the Transit Authority that they get a competent consultant in their drug cases and I think they did engage Dr. Trigg as a consultant for the Transit Authority.

Q To your knowledge, Dr. Gollance, have any Transit Authority officials ever accepted your offer of cooperation to screen prospective employees for them?

A I don't know as far as the methadone program. I know they have used-- I think they have used Dr. Trigg in some of their problem cases, not those on methadone. I think Dr. Trigg is coming here. I'd rather he answer that.

THE COURT: He will.

MR. BALBER: Your Honor, this concludes our direct examination of Dr. Gollance.

I might suggest to the Court, your Honor, that if you would like further information on specific referral techniques and criteria applied, that Miss Wolkstein might be recalled.

CROSS-EXAMINATION

BY MR. DUNN:

Q Good morning, Dr. Gollance.

A Good morning.

Q Beth Israel is one of many programs in the City of New York, is it not, Doctor?

A Yes. We were the pioneer. We are the oldest one.

Q You account for 35 or 36 of the existing programs?

A That's right.

Q How many programs are there in the City?

A Oh, I guess over a hundred.

THE COURT: So Beth Israel is one of a hundred?

THE WITNESS: Yes. But we have approximately -- there are about 35,000, 35,000 addicts under treatment in known methadone treatment programs. We have roughly a fifth or a sixth of them.

Q How familiar are you with the operation of the hundred other methadone programs?

A Well, I'm familiar with some of the large ones since we helped them organize and I'm familiar with the one at Bronx State. I'm familiar with the one at Kings County that they set up. I'm familiar with the City program which was the largest program and Dr. Newman, who organized that modeled their program after ours.

Q How familiar are you--

A Dr. Newman's program, that's the city program, I think, had something like 11,000 patients in their program.

Q How familiar, Doctor, are you with the private programs? Are there a group of programs referred to as private programs?

A I am familiar with some of them. I am not familiar with all of them.

Q Do all the programs deliver the same quality of service to the patient?

A I don't know. I haven't been around to evaluate them. I would suspect from what has happened or what I heard happened, some of them do not. I have hopes that now with the state regulations and the federal regulations being so rigid, that they will make them conform to a good level of service.

Q What are these things that you refer to as having heard happened.

A Well --

MR. BALBER: Objection, your Honor.

THE COURT: What is the question?

(Question read.)

MR. BALBER: Your Honor, the witness testifed he merely heard some things which can best be characterized as hearsay. He stated he had evaluated no such programs, had not helped establish any such programs.

MR. DUNN: The witness based his opinion on certain things. I am trying to elicit--

THE COURT: You are going to have a problem here. It is relevant to have information about other programs besides just Beth Israel and I assume that people who have as deep an experience as Dr. Gollance knows something about the other programs.

How they get it, they probably don't get it by going and physically standing at the door and I don't think we are going to get a lot of people who -- we can't just have a parade of thousands of people coming here, so I would be inclined to try to use Dr. Gollance's knowledge.

am BY THE COURT:

Q What knowledge do you have of the other programs?

A Not very specific knowledge. We did help close up some of the bad programs. That Dr. Jan Program, for example. When we heard what was happening.

Q Tell us about that?

A This is some years ago where this private physician, there were no regulations really in effect then, had this large program where basically it came down to you paid $20 and you got your methadone, whether you were an addict or not. They didn't do any screening. He had as many patients in his one office as we had in our clinic at that time.

So --

Q They were just buying methadone?

A That's what it amounted to in many cases.

Q Was he closed up?

A Yes. The federal people closed him up. But I don't think an operation like that could go on today.

Q Do you know of any?

A No.

Q I think Dr. Gearing told us there are certain clinics like Beth Israel that are monitored by this committee at Rockefeller Institute or Columbia, whatever it is.

A Yes, she has quite a large number.

Q Some of them are not monitored?

A I believe that is so.

Q The clinics that are not monitored, is there any distinction in quality between the monitored and unmonitored that you know about?

A I can't testify on that. They are monitored by the state and federal government but they don't report into Gearing for her statistics.

Q What variations in quality -- it is essential for me to understand from whatever source I can get it that really has knowledge of what variations in quality there are. We have heard a lot about Beth Isreael but Beth Israel isn't the only one.

A Most of the good clinics, first of all, have to have a competent physician running the program.

Q You say the good clinics. Are there clinics that aren't good clinics?

A There are some private clinics that I would question the direction, yes, there are some.

Q Can you give me the names?

A Not offhand.

Q Well, about how many -- what kinds of things are these?

A I would rather not answer that because I don't have direct knowledge. It is just some hearsay and that would be really up to the state or the federal people who review them to say.

Q Who would know? Who could come in and tell us about these other clinics?

A Drl Josephs might know.

Q Who is Dr. Josephs?

A Seymour Josephs. He is with the Drug Abuse Control Commission and he has the responsibility of supervising methadone programs.

Q Is it a function of the size, a smaller clinic can do a less good job than a bigger clinic?

A No. Size can be a factor but in my opinion the important thing is the people running it. You know, just like any medical clinic. You have a poor doctor running a cardiac clinic, you have that possibility or a cardiac program. And you have -- where you have the human element, you have that possibility.

Q Obviously; and suppose if somebody -- if you are worrying about getting expert judgment on employability, I guess the quality of the judgment would be dependent on the quality of the man passing the judgment.

A That is right. You know, there are enough people who have real experience in the field and knowledge, that any organization if it wanted could use them and consultants and advisors. You get into this thing that no matter what you do, there are always going to be a few poor ones and are you going to condemn an entire group because there is the possiblity that there might be a poor clinic? What you ought to do, of course, is put that one out of business as soon as you can.

THE COURT: Okay.

BY MR. DUNN:

Q Is there any central group that would be able to provide an evaluation to an employer with respect to a methadone patient in a particular program, other than the program itself, Doctor?

A Well, I think your best bet is --

Q Is there such a group?

A At the present time?

Q Was there ever.

A There was an attempt made in the City to have a group to certify, not just methadone patients but any addicts of their capabilities for employment and things like this and it was supposed to be under the aegis of the city but I don't think they were able to do it. They started butit didn't go through.

Q I ssuch a board in existence today?

A Not to my knowledge.

Q Would it not be of assistance to an employer to have an objective evaluation performed by an outside independent board, at least independent of the particular program?

A It could be done.

THE COURT: Provided the employer would listen but if they are not going to bother to listen, what is the use of having the board.

MR.SUMMERS: There is no one to listen to it at the present time, your Honor.

THE COURT: No one listening.

Take a short recess.

(Recess.)

THE COURT: I have a suggestion of an impartial board. Can we pick, settle on that basis? Can we settle on the basis of having an impartial board to review employees?

MR. DUNN: We intend to pursue that subject further this afternoon, your Honor.

THE COURT: Pursue it how?

MR. DUNN: There had at one time been such a board in existence and I'd prefer letting the people who were connected with the board testify as to the problems --

THE COURT: I thoughtyou were coming forward with a settlement.

MR. DUNN: No, your Honor.

THE COURT: Go ahead.

BY MR. DUNN:

Q Are you familiar with a Dr. Salazar?

A No.

Q Have you heard of Dr. Salazar?

A No, I think I saw his name. Is it on this list?

THE COURT: I am not hearing.

THE WITNESS: I don't know him. I never had any details with him that I know of.

Q Do you know of the methadone maintenance programs that are run by the Margaret Scranton Foundation?

A Yes, I know of them, yes.

Q Would you characterize them -- does that refresh your recollection with respect to the name Dr. Salazar?

A No, I know of the --

THE COURT: Is it Margaret Scranton or Mary Scranton?

MR. DUNN: Mary Scranton.

A Inknow the doctorin charge. I have met him superficially. The one wh organized this. His name just slips my mind for a minute.

THE COURT: Is Salazar head of the Mary Scranton Foundation Clinic?

MR. DUNN: Yes, your Honor.

THE COURT: Go ahead.

Q How would you characterize the maintenance, methadone maintenance programs run by the Mary Scranton Foundation with respect to the Beth Israel programs?

A I am not in a position to do that. I really don't know their programs except by hearsay.

Q Are there any programs other than the Beth Israel program with which you are sufficiently familiar to form a basis of judging the program?

A Yes. As one private run program, the Mora Program that is supposed to be run, from reports I get it is supposed to be run well.

Q What is the extent of your knowledge of that program?

A I have had some dealings with them. Under the regulations, private clinics were supposed to have a hospital to back them up and they wanted Beth Israel to back up their program so I had occasion some time ago to look into it and we were willing to work out something but they made other arrangements and we would have been willing to back that program. Is it Talbott who is the head -- it begins with a T.

Q Other than that program are you familiar sufficiently with any of the methadone programs in New York City, have a basis for judging programs?

A Yes. I am familiar somewhat with the city programs that are run in the various hospitals, in conjunction with various hospitals in the city. The Bronx State Program run by Dr. Lowinstein. The Kings County Program under Dr. Kissin.

Q The Veterans Administration Program?

A I have only had superficial contact. We provide them with some consultation, Dr. Trigg again, he is the Veterans Hospital in New York City and some time in the past I went out to the Brooklyn VA Hospital but at that time they were run somewhat differently than we run our programs in that at that time it was basically an in-patient program. We used to do that some years ago but the programs we run now are ambulatory programs. That's about the sum of my knowledge of them.

am

Q Assuming, Doctor, that an employer accepts your evaluation for a prospective employee and does in fact engage this person in a particular capacity as an employee, does not the employer run some additional risks with respect to this employee that he would not run with respect to an employee not a patient in a methadone program?

For example, might there not be a failure on the part of the program to adequately treat this patient?

A That might happen. It is theoretically possible. It could happen in any medical program if somebody doesn't do what they are supposed to.

Q Do not, Doctor, the federal regulations with respect to confidentiality of information concerning the patient, do not these regulations prevent the program from providing certain information to the employer?

A They are rather rigid, the regulations on confidentiality. We have had our legal people look into it and we think we could get proper consent from the patient which would be a valid consent to give the information that an employer culd use.

Q If the employee withdrew his consent which had been given previously to the program, what information would you then provide to the employer?

A If he withdrew his consent, we wouldn't give any information.

Q With his consent, what information would you provide on an ongoing basis?

A We would give you the initial evaluation when you first hire him and there would be nothing to stop the Transit Authority or any other employer to having follow-up reports from our people.

Q What information would you provide the employer on a non-going basis?

A His attendance at clinic and the evaluation of the counsellor as to how he is doing.

Q Would you report illicit drug use to the employer or the employer's medical department?

A I don't know.

THE COURT: You are now assuming there has been a waiver or consent?

MR.DUNN: I am assuming the consent has been given by the employee to the release of the records. The consent remains in force. I am asking whether or not the doctor's program would, with this consent and at the request of the employer advise the employer of illicit drug use if it appeared in the clinic's files.

THE COURT: All right.

THE WITNESS: I would have to recheck that with our legal people. If we got a full consent, we might do it, but I point out you have a medical department and there is nothing to stop you at the least suspicion of getting an examination done on the individual.

Q You have offered, Doctor, to have us rely upon you?

THE COURT: Let us not argue with him.

The thing is, a patient in a methadone clinic gets a urinalysis on a regular basis, right?

THE WITNESS: Yes.

THE COURT: I guess we have had this before, but how regular is that, generally?

THE WITNESS: They get a determination of morphine once a week. That is required by federal regulations and they can get any other screening that the doctor wants any time he wants it.

THE COURT: You say for morphine?

THE WITNESS: That is the way you test.

THE COURT: Are they routinely handled for any other drug?

THE WITNESS: Not routinely. They will do a full screening on the average once a month.

THE COURT: The morphine is required?

THE WITNESS: Yes, and that would reveal heroin.

THE COURT: Because the morphine turns into heroin in the body?

THE WITNESS: Yes.

THE COURT: You have a screening for morphine once a week. The point is, you do it much more systematically than the employer would do it and you are not certain even with any kind of consent that you could give the results of that to the employer.

THE WITNESS: The point is, our experience has been when a patient begins to abuse other drugs and do those things, it is shown in his behavior. He will miss appointments, he will not do what he is told so that soon shows up and it would be obvious not only to us but if he were holding a regular job with anybody, the employer would see it too.

THE COURT: Is there any way that you can tell me the frequency or the proportion of people that do get back to real drug abuse while they are methadone patients?

THE WITNESS: In our program, practically nobody uses heroin after the first six weeks. It is quite common when a new patient comes in and he may not believe he is not going to get any effect from the heroin while he is on the methadone, he may try it, but after the first six weeks roughly or eight weeks at the most, none of our patients use heroin and anybody who is using it in those first few weeks turns out to be either a needle addict or has some psychiatric problems that appear very soon.

So the patients are not using heroin.

THE COURT: When you say people in the program, are there people who drop out of the program that you are not including in your last statement?

THE WITNESS: That is right. We have roughly 20 per cent dropout and to retain 80 per cent is very good.

THE COURT: Where do most of those 20 per cent drop out?

THE WITNESS: At various times in the course of a program, for various reasons.

To give you one example, there are certain patients that we wouldn't have taken them in some time ago. We would take them in now and follow them. We know they are risk patients. If they act up or something happens, they may be dropped out.

A certain number move. Some die. We have patients 60, 70 years of age. There are various reasons for dropping out.

THE COURT: Would it be fair to say that if you look at the methadone clinic population, we have a 20 per cent risk of resumption of drug abuse and dropping out of the program?

THE WITNESS: But those patients -- that includes everything.

THE COURT: That inludes the whole?

THE WITNESS: That includes all cases and these patients are apparent to the staff treating them.

THE COURT: When you say all causes. The dropouts are for various causes, not only drug abuse?

THE WITNESS: That is right.

THE COURT: Is there any way that you could say if we took the methadone patient, what is the percentage of risk to serious drug abuse?

THE WITNESS: That is not high. Excuse me. By serious drug abuse, do you mean heroin?

THE COURT: No, I really don't. I mean, everything I am really asking relates to employability so I am saying the kind of drug abuse that you would be worried about if you were sitting in the Transit Department.

THE WITNESS: Fran Gearing has the exact figures on that but I will point out, when a patient begins to do this, it is apparent to the staff, this is not somebody we are going to recommend for somebody. For example, we will now take in patients who have a definite psychiatric history. Nobody is going to recommend that individual and we will try to treat him as long as we can but if he acts up, we have to drop him or get some other care for him, but that is known to the staff.

THE COURT: I think it is reasonable to say if you are employing somebody, you are worried about whether he is going to somehow foul up before you can detect it.

Sure, after he has been back on heroin for a little bit, you could detect it, but he is not going to announce when he starts back on heroin, is he?

THE WITNESS: In our program, he might. Of course, one of the things we do, that we try very hard to do, is to run this as a medical program and to encourage the patient to tell the staff his problems so we know what his problems are and to see what we could do about it, and we will encourage him so we could work with him on that.

I am talking about the majority of people we treat that it is well-known to the staff. They can tell as much about him as you can and if they are clear -- of course, there will always be some risk no matter what you do, but if they are cleared, it is a pretty good bet.

Suppose you recommended somebody that wasn't good, you wouldn't put him in at a sensitive job just when he starts and if he starts to act up, it will show in his work performance and the employer will have plenty of opportunity to know about it.

THE COURT: I don't mean to be picky --

THE WITNESS: If you have an employee and he is coming in regularly, he is doing his job well, his supervisor reports he is doing his job well; on the other hand, if you get somebody that is not coming in, his work is lousy, sloppy, it will soon be called to your attention and since you know his history down there, it would not be difficult or even if you didn't know his history, you might well refer that patient to your medical department for check-up.

THE COURT: Let me cite you a case. A fellow I tried for attempted bank robbery a year ago is a man who had been a heroin addict off and on for many years, something like 15 years, and had a terrible problem.

He went into I think it is ARTC. He was on a methadone program for, say, three or four years. Maybe I am exaggerating, maybe it is two years, something like that. He was really trying to pull himself together.

He got a job in some community center doing some kind of work- I can't recall very well. All of a sudden there was a terrible problem with his girl friend. His girl friend walked out, and he lost his job about the same time but the emotional strain is too much for him and he goes on a drug binge. He takes everything you could possibly put together, heroin, cocaine, amphetamines, barbiturates, wine, and then he walks into the Chemical Bank and tries to rob it.

I don't know all the circumstances. I don't know whether there were observable symptoms of depression or mental probelms but my impression is, it was something rather whthout warning as a result of a strain he could not sustain.

What are the chances with these people with just sudden return to drugs because they can't cope any other way?

THE WITNESS: If they did return to taking all the drugs you mentioned, that type of behavior pattern, I would think that would be recognizable to an employer.

THE COURT: He is sitting in his apartment guzzling this stuff and the next thing he does, he walks in and robs a bank. Nobody is observing him.

THE WITNESS: I am sure if he was working before that happened, he would have had a very poor work history. There would be enough signs there and his colleagues would know that there is something wrong.

THE COURT: You don't think you are likely to have a sudden precipitant, unannounced return to drugs where you do damage before anybody can recognize it?

THE WITNESS: I don't believe it would be that sudden. I think it is recognizable fairly easily.

You know, there is no 100% guarantee in anything we do and I don't know that we could set a standard of conduct for this group very mugh higher than anybody else you have employed. Almost anything can happen to anybody. We know people, you see them work, very regular jobs, and crack up and do the most awful things.

THE COURT: All right, I get your picture.

Q Doctor, are you aware of a study that was conducted by Doctors Chambers and Taylor with respect to the use of illicit drugs by methadone patients who had been in treatment for a period of at least 14 months, and are you aware of their findings that in the one-month period, 97.6% of these patients used illicit drugs?

Are you aware of the study?

A Yes, I know it was done and there are a lot of criticisms of those findings and I would rather Trigg discuss that.

Q Are you aware of the study done by Dr. DuPont of a similar group in which he found approximately 55% of the patients using an illicit drug at least once in a one-month period?

A It also depends--

Q Are you aware of the study?

A Yes.

Q Are you aware of the difference in the studies that Dr. DuPont's group excluded amphetamines and barbiturates as illicit drugs and considered only the drugs that Chambers and Taylor had exclusive of amphetamines and barbiturates?

A I read that quite some time ago.

Q Does this not present an additional risk to an employer?

MR. BALBER: Objection.

THE COURT: Overruled.

A I would have to review that study again. There are a lot of criticisms of it.

Q Assuming the studies to be true, would this represent a risk to the employer?

THE COURT: Let's hear what he has to say.

You look at your patient population and would Chambers or anybody recommend those people to you?

Q I am asking you whether this represents an additional risk to the employer?

A If it were not known, it might, but if you were watching your patient and you knew he wasn't using those drugs and his whole history is good --

Q In your program --

THE COURT: Look, Mr. Dunn, let him finish and I will let you finish.

A There are different patient populations with different problems. If they are having those types of problems, you will not recommend them for employment and if you have them under observation for a year, you will not send that patient, and I would like to know, too, how much they used. For example, if we-- I would have to review that study again rather carefully.

Q What percentage of your patients in treatment for a period of 14 months do you find use illicit drugs?

A I think Frank Gearing has the exact figures.

Q Do you know the answer, Doctor?

A Roughly; none of them use heroin. I would have to look that up again.

Q You are saying none of your patients use heroin?

A After the first two months.

Q None of the 6,551 paties you had as of November 25, 1974, used heroin in the preceding month?

A Not from our findings.

Q And you tested each of them for the heroin derivatives?

A Yes.

Let me point out there are different methods of running methadone programs and when you say a methadone program, you have to define what you mean, and let me say we use at the beginning what we call blocking dosages which are relatively high doses of methadone so they don't get an effect from methadone.

If you have a so-called methadone program that is using low dosages, then it is possible for them to take heroin, but if you use the standard Dole-Nyswander techniqu, then they don't use heroin. That is why I wanted to see what the amount was that Dr. Chambers reported.

I haven't read it in some time and I would like to review that.

t5 am Q I can appreciate that, Doctor. Your program, as I understand it, is a high dose program?

A Yes.

Q ARTC, for example, would be what?

A I see Dr. Prima is coming down, they use all sorts of doses, I believe.

Q It differs from the doses you use?

A I believe it does.

Q You mentioned the very beneficial effect of the methadone programs on soceity with respect to decreasing crime. Did you base that on any study or research?

A Yes. It is based on Dr. Gearing's reports. It is also based on -- I don't have a statistical fact in our clinics. I mentioned one clinic where over 90 per cent are working and they have had practically no arrests of their patients. That is the major studies. I think Dr. Cushman issued a report on the economic impact on his program.

Q Did Dr. Lukoff do a study of the ARTC opulation?

A I knew they were doing a study but I didn't see it. Their population and their treatment methods are somewhat different from ours so -- again, I am not that familiar with them that I want to comment on ARTC.

Q You mentioned one clinic, Doctor, that has, I believe you say 90 per cent of the patients gainfully employed?

A Yes.

Q Do you know how many of these patients have been discharged from employment this past month?

A No, but I could probably find out. I can tell you which clinic it is and we could probably find out. I am sure they have the records. They would know. But I don't know them offhand.

Q You keep records of job performance of people that have been discharged?

A We know when they are discharged.

Q Do you keep records which show that?

A Yes. The patients usually bring in their pay stubs.

Q Are these records readily available?

A To proper sources, yes. They are reported to Fran Gearing. Each clinic has a standardized way of reportin and that is one of the things they report to Fran Gearing.

Q Do you know what percentage of your employees are discharged from employment because of poor job performance?

A We would only know the percentage who lost their jobs. I don't know whether we would -- the counsellors might know the reasons but we wouldn't have that in a statistical report.

Q Wouldn't this be one predictor of success with respect to the people you are evaluating?

A You mean holding jobs?

Q No, whether or not they have been discharged from jobs because of poor job performance.

A Yes, we are very concerned. Very often, as you say, the reasons for discharge, they are laid off for no fault of their own. Yes, I think that would be important to know and I suspect the counsellors would have that but I don't think we statistically break down the reasons for losing a job on those we report to Columbia. We just report those who were employed, the percentage employed.

Q This 90 per cent you are talking about are persons who sometimes during the month have been employed, not necessarily the entire month?

A Well, at one time there was 90 per cent of them out working, yes. It may mean job turnover, probably. I mean, the point is if you reduce it to 85 per cent or 80 per cent, the facts are there is a very high percentage of them employed in that group.

Q Before recommending an employee or giving a favorable evaluation of an employee, would it not be necessary for you or whoever in your program is delegated such authority to know specifically what the position is of the person who is being considered, what his hours of work are, when he is working at night or during the day, whether he travels or whether he supervised?

A Yes, we have a group, Irene Wolkstein has the group that supervises -- our vocational rehab counselors are very interested in the jobs and what the job specs of the employer was. We try very hard to meet those. We are anxious that our people perform well so we do try to select them when we think they will do a good job, yes.

Q With respect to the employers with whom you have had a degree of success in placing your patients, do you know whether these employers provide any support service to these patients?

A As far as I know, they don't. They are treated just the same as any other employee and as a matter of fact I would hope that it would be kept confidential that they are patients.

Q Do you know if any of the employers require these employees to agree to submit to periodic and unanticipated urinalysis?

A I don't know offhand.

Q Would you criticize such a procedure?

A No, I wouldn't. And if the employee agreed to take it with those ground rules. At least for a certain length of time. I think after a while he should be treated as a regular employee, once you are satisfied he is doing well. The goal is to get these people back into society and working and if you are always constantly treating them as different, I don't think that that is good in the long run. At the beginning and for whatever period you want to do it and I think after that they ought to be, and there work performance has been good, everything you can see, they ought to be treated as regular employees.

If you have an annual physical or you want a monthly -- whatever your ground rules are and the employee agrees to it, that can be set up.

Q Would you say there is a rational basis for requesting at least initially that the employee submit to a periodic and unanticipated urinalysis?

A I would have no objections to it. I don't know if there are any legal technicalities --

Q No, based on your experience, Doctor, would you say there is a rational basis for an employer to request this?

A Yes. To satisfy him. The important thing, to me, it would seem is how this fellow is performing.

Q What is the rational basis for an employer requesting this. You say to satisfy himself, to satisfy himself about what, Doctor?

A That his employee is not abusing drugs. He is usually very uptight about it. I mean, he is presumably under treatment all along. He hasn't given up his treatment just because he is working, so he is being evaluated constantly there and he is probably being evaluated where he is working.

Q But I am still unclear as to what extent the evaluation that takes place at the methadone programs would be communicated to the employer.

A Well, at the initial thing we would give you the full report.

Q Which would include what, Doctor?

A Would include how long he has been in the clinic, how he has done. Almost any of the medical information that we had that was at all pertinent and the opinion of the people who had been working with this man. The doctor, the counsellor, the vocational rehab counsellor. Those people who have been working with him and know him.

Q And assuming we employed this person based upon your representations and one month later we requested that you provide additional information, to what extent would you provide additional information?

A Get the patient's consent.

Q With the patient's consent?

A Yes. We would not give it without the patient's consent and it was a proper consent, considered proper legally, then we would give it.

Q What would you give?

THE COURT: I didn't follow that.

MR. DUNN: Your Honor, I amnot clear --

THE WITNESS: WE give you any pertinent information we have. For example, that he is attending clinic regularly. Whatever reports that were --

Q Would you tell us that he presented a urine containing morphine?

THE COURT: He said earlier that he would have to consider that. You know, you can only get -- you don't have to have the same thing answered five times. It is inconclusive but --

THE WITNESS: I would point out to you it is to our interest to see that our patients perform well and we would be as cooperative as we are permitted to be.

THE COURT: I suppose under certain circumstances that if the employee did not give a reasonable waiver of confidentiality, he wouldn't get employed. So I don't -- this is not a matter of life and death. I feel it is something that could be worked out if it comes to that.

Okay. Anything else?

MR.DUNN: I have nothing further, your Honor.

THE COURT: Okay.

THE WITNESS: Could I make just one comment?

THE COURT: Certainly.

THE WITNESS: From the public policy point of view.

There must be at least 300,000 heroin users in New York City. In our own Bernstein Institute we have had a hundred thousand admissions, just a detoxification service, not methadone, since 1961 and this represented over 50,000 individuals. Here we have a mass of people, you know, many who started when they were young and are you going to perpetually condemn them so they can't get back into society? I think -- well, all right.

THE COURT: Thank you very much.

THE WITNESS: Thank you.

(Witness excused.)

MR.DUNN: Your Honor, Dr. Kreek is here and she has asked to be excused briefly.

(Discussion off the record.)

CURRICULUM VITAE

Mary Jeanne Kreek, M.D.

Birthdate: February 9, 1937 Place: Washington, D.C.

Marital Status: Married - January 24, 1970
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EDUCATION: Woodrow Wilson High School - Washington, D.C., 1951-1954
Wellesley College, Wellesley, Massachusetts, 1954-1958 - B.A.
Columbia University College of Physicians 1958-1962 - M.D.

ACADEMIC HONORS: High School
Westinghouse Science Talent Search - Top 10 - 1954

College
Associate Member - Sigma Xi (Full membership - The Rockefeller University)
Phi Beta Kappa
Durant Scholar
Special honors in chemistry

Medical School
Bordon Award for Research

MEDICAL LICENSURE: New York State; California; District of Columbia

SPECIALTY BOARDS: Diplomate - American Board of Internal Medicine

FELLOWSHIP: USPHS Post-doctoral Fellow, 1965-1967

INVESTIGATORSHIP: Career Scientist of the Health Research Council of the City of New York, July 1974-

BEST COPY AVAILABLE

PITAL APPOINTMENTS:

Intern in Medicine, 1962-1963 - The New York Hospital
Assistant Resident in Medicine, 1963-1964 - The New York Hospital
Assistant Physician in Medicine, 1964-1966 - The New York Hospital
Physician to the Out-Patient Department, 1966-1967; 1967-1968; 1968-1969; 1969-1970; 1970-1971 - The New York Hospital
Assistant Attending Physician - The New York Hospital 1971- present
Associate Physician to the Rockefeller University Hospital, 1967-1972
Physician to the Rockefeller University Hospital, 1972- present

EDICAL SCHOOL AND RESEARCH INSTITUTION APPOINTMENTS:

Fellow in Medicine, 1965-1966 - Cornell University Medical College
Instructor in Medicine, 1966-1967 - Cornell University Medical College
Clinical Assistant Professor in Medicine, 1971- present - Cornell University Medical College
Assistant Professor, 1967-1972 - The Rockefeller University
Senior Research Associate, 1972- present - The Rockefeller University

RGANIZATIONS:

Sigma Xi - The Rockefeller University Chapter;
American Federation for Clinical Research;
American Gastroenterological Association (Associate Member-1969; Member-1970)
Fellow of the American College of Physicians (1971)
The Endocrine Society (1971)
American Association for Study of Liver Diseases (1974)
Association of Career Scientists of the Health Research Council of the City of New York (Member 1974)

MITTEES:

NIH-HEW: General Medicine A Study Section (1973- present)
NIAMDD: Committee on Human Experimentation (1974)
FDA-HEW: Consultant to Bureau of Drugs (1974- present)
Health Department of the City of New York: Technical Advisory Committee on Pharmacology (1974- present)

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MARY KREEK, called as a witness by the defendants, being first duly sworn, testified as follows:

MR. DUNN: May I request the Court to advise the witness of the reason for her being here.

THE COURT: As you probably know, at an earlier stage in the trial I have requested for my own benefit the presence of further experts and we did understand that some experts were a little reluctant to get involved in this case. People were reluctant to get involved in litigation and in view of that sensitivity, the parties were holding off handing on people with subpoenas and so forth, so I just decided that I would step in and request the presence of additional witnesses and we are all trying to go at this as objectively as we can. You don't become partisan by appearing here. You are just really helping me as the Court.

THE WITNESS: I understand.

THE COURT: Go ahead.

DIRECT EXAMINATION

BY MR. DUNN:

Q Dr. Kreek, did you present me with a curriculum vitae?

A Yes.

Q Does this accurately reflect your background and experience?

A It certainly does.

MR. DUNN: I offer this, your Honor.

THE COURT: We will mark it later. It will be the next defendants' exhibit.

BY MR. DUNN:

Q I have just a few questions, Dr. Kreek. Did you perform a study that was reported at the Fourth Annual Methadone Conference proceedings?

A I did.

Q And did that study concern itself with the medical side effect of methadone?

A The title of the paper is "Medical Safety Side Effects and Toxicity of Methadone".

Q Did you in the course of that, the research, that resulted from that article follow 92 or did you study 92 methadone patients who had survived for a period of three years?

A I did.

Q Would the Court like to hear just briefly the design of this particular study?

THE COURT: Yes. Incidentally, the background sheet is Exhibit JJ and that will be received.

THE WITNESS: The study in question was a prospective study which I began in 1964 when I was first doing research at the Rockefeller University. And the study design was a prospective study of the first consecutive unselected 214 patients ever admitted to a methadone maintenance treatment program.

These patients were studied over a period of three or four years and at the end of a minimum of three years of constant high dose methadone maintenance treatment for heroin addiction, 129 patients were still in treatment orientation rate of 60 per cent.

THE COURT: That is going a little too fast for me.

THE WITNESS: I am sorry.

THE COURT: You tried to study the first 200 patients in methadone maintenance programs?

THE WITNESS: Correct. The first 214 consecutive patients.

THE COURT: Then go ahead and give me that again.

THE WITNESS: Surely.

These were all patients admitted between the dates of January 1, 1964, when the very first patient, experimental patient was admitted to the Rockefeller University Hospital for research purposes, up through July 1966, and the study had its termination point on July 1969 when the last admitted patient had been in treatment for three years.

THE COURT: Let me get that.

The termination point was what?

THE WITNESS: July, 1969.

THE COURT: That meant that the last of these patients --

THE WITNESS: Had been in constant daily chronic methadone maintenance treatment for a minimum of three years.

THE COURT: Go ahead.

THE WITNESS: But obviously those that were admitted in '64 had been in treatment at that point for five and a half years.

THE COURT: All right.

A At that time, July, 1969 after three or more years of chronic methadone maintenance treatment, 129 of this very first group of patients ever admitted to methadone maintenance treatment were still in treatment. All of the charts of these patients were reviewed. They had all been studied according to the prospective protocol that was designed. In addition, in the summer of 1969 and the ensuing months after that time, 92 of these 129 patients were specifically reinvestigated and those 92 were not selected, they simply were those who we were able to visit within a rather extended --

THE COURT: When did you do the investigation?

THE WITNESS: In the summer and autumn of 1969.

92 of those patients had blood specimens drawn and I think I better add a medical point here. Why -- we drew blood specimens on 78 of the 92 who were reinterviewed and the reason blood specimens were drawn on only 78 of the 92 whom we had visited at that time and reinvestigated intensively at that time was that I drew blood only from the antecubital fossa right here in the arm which is a common place to draw blood.

Mahy of the patients in this study had been heroin addicts for as long as 55 years and the means years of heroin addiction before treatment in this first group was 14 years. And many of them had very chronicly injured arm veins. Blood can be drawn from other sites and they are in the course of medical care drawn from other sites but I did not feel it was justified to draw blood from other sites in the course of a routine follow-up of this type. So blood specimens were obtained on 78 of the 92.

THE COURT: And the others you didn't think it was safe to draw blood?

A It would be safe to draw it. I didn't think it was necessary when they were well and healthy and had no observable problems.

All of them had blood specimens drawn at other intervals during their methadone maintenance treatment and we had the data from those other specimens.

THE COURT: I'm not clear.

The reason you didn't draw blood from the other 14 was that there was no indication of recent needle marks?

THE WITNESS: There was no indication of recent needle marks in any of these patients.

There was sufficient chronic scarring in the arm vein that it would necessitate drawing blood from another site.

These patients had all, I hasten to add, had blood drawn many times during their treatment for routine follow-ups. Since none of them had any medical problems at the time and since this was a research project, I didn't feel it justified to draw blood from an atypical site just for the purposes of the study.

If they had any medical problems, of course such blood would have been drawn.

All of the 92 patients were, however, examined and interviewed intensively.

THE COURT: Okay.

Go ahead, Mr. Dunn.

Q Can you tell me, Doctor, without necessarily commenting on the significance, whether these were your findings: of this group 49% exhibited or complained of a side effect of sweating; is this true?

A 48%, upon specific questioning of: "Do you think you have normal or increased sweating," answered that they felt they had increased sweating. 52% said that they had normal sweating.

This was a subject of evaluation of the patient of his own state.

Q Was it your finding that 17% complained of persistent constipation?

THE COURT: What per cent?

MR. DUNN: 17 per cent, your Honor.

THE COURT: Let me see. We are talking percent of what?

THE WITNESS: Of the 92 that were specifically interviewed after three or more years of chronic high dose methadone treatment.

Q Is that correct, Doctor?

A Yes. 17% said on specific questioning that they had some constipation that required oocasional laxative use.

Q Is it true, Doctor, that you found that 50% entering the program complained of constipation and this was reduced to 17% by daily laxation?

A Oh, no, that is not true.

Can I clarify that?

Q Would you please?

A Yes.

Since constipation for reasons that are a little bit unclear to me, since so many people are constipated and Ex-Lax and prunes are very popular in our population in general -- since constipation had become a point that many people had a fixated concern, I was delighted that I had already built into my prospective design questions about bowel habits.

Indeed, these questions were asked from the time patients first came to methadone maintenance treatment.

Patients-- it is not 50, but rather 59% of this typical patient population, consdecutive prospective study population, complained of constipation requiring intermittent to daily laxative use.

During the first few months of maintenance treatment --

THE COURT: You are saying 59%?

A Of all of these consecutive patients coming into methadone maintenance treatment.

THE COURT: Of 214?

THE WITNESS: Correct. -- complained of laxative use intermittently during the first few months of treatment.

We went on further. The further data is applicable to the 92 patients specifically interviewed. Of that group the average, the mean months of laxative use at all was eight months. This was intermittent laxative use.

By three years or more, in other words, after that 1969 time point, only 17% of the patients stated that they still had to use laxatives on an intermittent basis to keep their bowels normal.

I don't know if you want a comment on this in context with the general population . I am a gastroenterologist as well as an endocrinologist.

Having worked in the GI clinic for many years, I can assure the Court and everyone else that a huge percentage of people use laxatives on an intermittent basis and I would suspect the 17% might be below the norm of the middle-age population.

Q Were these middle-aged patients?

A These patients had an age of 35 mean years. I'm getting around that area myself.

Q Don't you find, Doctor, that 16% of these 92 patients complained of sleep abnormalities, mostly insomnia?

A Yes.

THE COURT: What per cent?

Q 16.

A Either 16 or 17. I always have to -- it was 16, yes.

6b

Q Is it not also true, Doctor, that you found complaints from 22 per cent of these patients regarding sexual libido abnormality, 14 per cent were of an orgasmic nature?

A Yes. That is correct. 22 per cent. Again, this is on subjective questioning complained --

Q Did you, Doctor, study --

MR. BALBER: Objection. May the witness be allowed to give a complete answer?

Q The question was whether or not this was true, and the witness answered in the affirmative, your Honor.

THE COURT: The context helps me. Let us be a little more liberal.

Q Whatwere you going to say?

A I was going to point out two things. Again, these were specific answers to subjective questioning. I think this is an extremely important point for the Court to know about. These are the patients' own summation of their own sleep, their own libido, their own potency.

I spoke to Mr. Dunn last night and we discussed this casually, and I pointed out to him that it is unfortunate that no one has ever run a prospective study of any population and especially not an age, sex and economic and socio-economic status matched control group. But, again, and I think this is anectodotal, since I am an investigator, not just when it deals in anecdotes, I shy away from the anecdote. When we are left with anecdotes, having worked in endocrinology, gastroenterology and general medical clinics, I have to point out that insomnia complaints are extraordinarily common. It is one of the kinds of things that just people in general come to their doctor and say, "Doctor, I don't sleep too well," and, secondly, complaints about libido and potency are also common. There are some particular groups in which they are quite common. They tend to be young to middle aged men, they tend to be especially common for instance after the birth of a child. I think one thing I would like to point out is that when we cross correlated those who complained of libido abnormalities and potency abnormalities, with two other parameters, clinical functioning demonstrated by fathering of the child or bearing a child or hormonal levels such as TSH-LH, which are tropic hormones that control sex, steroid functions, and also made the comparison with sex hormone levels. There was no good corss correlation between the subjective finding or complaint and the objective measurement or the clinical finding as I mentioned of child birth or fathering of a child.

Again, this is a common phenomena in endocrinology in general. When a male or female comes in complaining libido problems or potency problems, one of the first things that the endocrinologist has to do is try to sort out whether this is a psychological problem or hormonal problem or a mixture of the two. Frequently one finds a lack of correlation just as I did in this particular sequence of patients.

I am speaking now frequently in a population that are not drug users, being treated on any drug or any other parameter, pharmacologic nature.

eot 6b

Q Did you conduct any study, Doctor, or are you aware of any parallel study that's been conducted on a non-methadone program with respect to eliciting these side effects?

A Not a good one. Especially not one in economic matched groups. What one would really need to do is match age, sex and social economic status and I stress this in any kinds of studies if one would really like to come up with firm data on many things, this must be done.

On the other hand, the reason it is not done is because of the practicality of the issue and the lack of research funding at this point, and for the past few years, to carry out what would really be ideal, but again, these questions have come up with regards to the effects of a lot of agents and I think we can look at these data compared with other data that have been forthcoming and the anecdotes which, oh, vast number of specialists could give you, and you will find that the consensus is that a less than 20% figure is not considered an abnormal figure for these parameters.

MR. DUNN: I have no further questions, your Honor.

THE COURT: Did your analysis have to do with use of other drugs besides methadone?

THE WITNESS: It is a very important question, your Honor. And obviously we were dealing with patients from three to five and a half years on treatment, but I felt that it was critical for me to ask the question at that three or more year time point of, is each of these individuals still in treatment, the 129,000, and, of course, especially the 92 who were specifically interviewed, are any of these individuals continuing to abuse any drugs and we did this in two ways.

One was by specific questioning and although I know many may recoil at this, if you have good rapport with patients, even if the investigator, when you may not know the patient well, this good rapport may be rather rapidly established, you can get the right answers but we did both.

We also looked at the records of urine monitoring.

If I could just open my own paper to give you the precise numbers on this.

THE COURT: Certainly.

THE WITNESS: It is in the JAMA paper. This was a paper which is entitled "The Medical Safety and Side Effects of Methadone in Tolerant Individuals" --

THE COURT: Is this a different study?

THE WITNESS: Yes, it is. I think it is important.

Possibly the Court would like to put into the record a couple of these papers that have been published in major national medical journals that have been reviewed but in any event, this is in the JAMA.

THE COURT: Journal of the American Medical Association?

THE WITNESS: Correct.

THE COURT: What is the name of that paper?

THE WITNESS: "The Medical Safety and Side Effects of Methadone in Tolerant Individuals."

In this there was continued evidence of heroin abuse in two of the 128 patients-- 129 patients.

THE COURT: Wait a minute. I thought we were talking of the 129.

THE WITNESS: Yes.

THE COURT: Are we talking about the same group?

THE WITNESS: Yes, sir.

BY THE COURT:

Q And you had evidence of --

A Of continued intermittent heroin abuse in two of the129. And I'd like to point out that that --

Q Just one second, please.

When was that paper put out, by the way?

A February 5, 1973.

Q What did you want to point out?

A I wanted to point out that the evidence that those patients were continuing to abuse heroin was apparent both from reviewing their urine monitoring results and by historical questioning of the patients.

In both cases it was extraordinarily sporadic but it did exist and could be confirmed by two ways known to the patients, to their doctors, to their counselors, to their clinic.

Q How?

A By interview and by urine monitoring.

Q Was this something that was discovered--

A Because--

Q At the time of your study or had it shown up before?

A It had shown up before.

Q Had it shown up regularly before?

A It had been intermittent whenever the use itself had occurred, since the use itself was intermittent.

Q How about the, how about use of other drugs?

A Six patients intermittently used other drugs and I must use the word, I think here, use and not abuse. It is becoming a difficult value judgment, I'm afraid in our population at this time, but the other drugs used included Valium and barbiturates.

Q Barbiturates and what?

A Valium.

Q How do you spell that?

A V-a-l-i-u-m, and I should give you the generic name which is Diazepam.

Q And then is it Valium?

A Valium. V-a-l-i-u-m.

Q What is that?

A It is a tranquilizer muscle relaxant and the reason I point out that this has to be viewed in context of our general population is that the use of Valium has now become second, I believe, only to aspirin in our general population.

It is an extraordinarily commonly prescribed -- I think JAMA found it was the No. 1 prescription drug last year. It is extraordinarily commonly prescribed. And widely used by many people for many purposes.

Q Any indication in the 129 that they had used cocaine?

A Not in that group.

Q When you say that group, we have been asking -- maybe I could just detoir a minute here.

We asked this morning, somepeople asked about the continuation of heroin or other drug use, right?

Dr. Gollance referred to Dr. Gearing's study which I have just looked through.

Is there anything in the record now that anybody knows about that talks about the frequency or gives any information about drug use by methadone patients, non-methadone drug use by methadone patients?

Is there anything except what --

MR. DUNN: There is a paper by Dr. DuPont which makes reference-- which itself reaches certain conclusions and makes reference to the works of Chambers and Taylor.

THE COURT: I am talking about something in evidence now.

MR. MORRILL: Your Honor, I have to check the transcript. If my recollection is correct, Dr. Cushman testified about drug abuse by people enrolled in his clinic at St. Luke's Hospital.

And Dr. DuPont also gave some statistics based on his experience in Washington, D. C. and programs comparable to those in New York City.

THE COURT: Let me ask you, Dr. Kreek; aside from this study of the 129, can you give us any information about problems of methadone patients reverting to heroin or going to other drugs or alcohol, anything like that?

THE WITNESS: Most of my work is investigation, clinical investigation, and basic investigation. So I have looked at groups of populations like these 214 patients and other groups of large or medium or small numbers of patients intensively.

Going from one drug to another, I guess is your question, or are they concomitantly using other drugs?

THE COURT: If somebody is on methadone, what are the chances that he, because he has gotten into some kind of drug habit, is going to suddenly slip back to taking heroin or if he doesn't find satisfaction in heroin, is he going to go to cocaine or some other problem drug?

THE WITNESS: Okay.

I have to speak for my research patients that I have looked at but at least in that group, including this prospective study, the incidence of turning to another drug has been extraordinarily low.

And in fact I think the very hard numbers we came up with in the prospective study are indicative of this.

THE COURT: You are talking of the study of the 129?

THE WITNESS: Yes. Only six of these patients were using other drugs. Unfortunately, I think, again, there is no study of any population, much less an economic age-sex match control group of other drug use.

Just interviewing people in medical clinics I find a very high proportion of males and females of all economic brackets and age groups that occasionally use a sleeping pill or occasionally use a tranquilizer, so I suspect, if anything, this group may have a lower incidence of concomitant drug use and I think there is probably a reason for this.

The ones who were looked at after three or more years of treatment obviously were those who were doing very well in treatment for the most part and they represent the majority of patients in methadone maintenance.

But getting away from the drug scene is very much a part of their treatment. I think there is another point that probably I should bring out, though. That is the question of alcohol which is frequently brought out.

The question is asked: Do patients turn from heroin to alcohol when they no longer are getting any high because they are being maintained on a proper dose of methadone.

I think it is extremely important to point out something that I was not taught properly in medical school. I was taught that people either used heroin or alcohol but not both, and when I came to this field in 1964, I had to relearn some facts and they had to be taught to me by physicians that worked in areas from which many of these patients come and the fact of life that I learned very early on was that there was a small but real percentage of patients and who were concentrated in certain population groups who used both alcohol and narcotics and in my prospective study design, I quantified roughly the amount of alcohol consumed by patients both at the time of admission and at the end of three or more years of treatment.

And the percentages remained rather stable over that period of time and the same people who abused alcohol continued to abuse alcohol.

One of the other reasons I did this was to sort out the different medical effects, if there should be any, of chronic methadone maintenance treatment, which was one of my two major goals in this particular study design.

About 25% of patients were alcohol abusers and 75% were not.

Now, again, and I come back to this, alcoholic abuse, as we all are aware, is really our No. 1 substance abuse problem in this country at this time and it is a substance abuse problem that pervades all economic brackets and all ages and sexes and I've talked to people in industrial medicine from time to time and most of them view this as the No. 1 health problem of employees and last night I was really happy to hear from the people at MTA that they have recognized the problem of alcohol abuse in their employees and in fact have a clinic and have had for 20 years, I guess, to help look into this problem and I think this is to be lauded because alcohol, unlike narcotics, when used properly, such as methadone, maybe in methadone treatment, does, in fact, cause a lot of deleterious effects in the body and I think it is terribly important that they have taken this leadership to attempt to treat their employees who are alcoholics or get them into treatment, but I think we have to view this narcotic group in the context of their own economic and social background and in the whole context, and we also must recognize that 25% do have alcohol abuse problems when they come to us and they continue to have these problems in many, if not most, cases.

THE COURT: You don't feel it increases, alcoholism increases because if somebody who was on heroin, he is onmethadone, he wants a kick and so he does something?

THE WITNESS: We thought that might be a problem because the kick had been taken away and certainly the 20% drop-out that occurs, about 5% of that drop-out occurs because the person has come into methadone maintenance, finds he can no longer get a high and wants to go back to heroin so he can get a high.

When we looked at this and tried to quantify it, in fact only 4% to 5% of patients began to use alcohol more heavily during methadone maintenance treatment and I have a feeling that's within the noise-signal ratio of our study. 4% to 5% is a low percentage I would not like to make a lot out of. It showed an increase in alcohol use.

I think a much more important number to fixate upon is this 20 to 25% that are abusers of alcohol both when they come to treatment and during treatment.

THE COURT: I want to make sure I understand.

When I asked you about the information you had about methadone patients abusing drugs, I was not focusing on taking sleeping pills. That's not a concern of mine.

I'm talking about going back to heroin. I'm talking about cocaine. I'm talking about the things that would, you know, you get the idea?

THE WITNESS: I sure do.

THE COURT: What I would like to know, you have given me the results of the study on 129, but in any more general way from other studies, do you have any other information that you can give me about the use by methadone patients of heroin or other of these which I will call the dangerous drugs.

THE WITNESS: These are hard data. Now I will go to just general observation; all right?

THE COURT: All right.

THE WITNESS: I think there is a difference and I have to sort the two out.

The genral observation is that once a patient has been satisfactorily maintained on methadone, and people have asked me, "How long does that take?" And I have had to give them answers that in some patients two days, and in some a year. But I would say the average is three to six months.

To be well-stabilized and beginning to completely get away from the drug culture, to begin to think about pulling together family and friends and to finsish education, seek a job- this all usually happens in the three to six month period of time.

Once a patient has reached successfully that point in his treatment, to return to heroin abuse is explicitly rare in my experience and in fact in many studies that I have done for other reasons, for other metabolic questions being asked - I have asked this question and if anything, many of these patients not unlike alcoholics successfully treated at AA have a religious zeal almost against heroin abuse. They really don't want to turn back.

Let me take the other question about -- and they also are anxious not to go to other drugs like cocaine or anything else that belongs very much to the drug culture.

Let's look, though, at that first three to six months of treatment, which is a very important time point.

THE COURT: So your conclusion would be it is extremely rare to have somebody, after they have become stabilized, go to --

THE WITNESS: Heroin or similar hard drugs.

THE COURT: When you say rare, I take it you are talking about something much less than 25%?

THE WITNESS: Yes, sir.

BY THE COURT:

Q Even less than 10%?

A I would say so but that's anecdotal. I rather insist on being precise in this study which was a three-year well-controlled study. It was two out of 129 in three years, so that puts it somewhat in the ball park.

I participated, as you may or may not have heard in your testimony, in the very first studies on methadone both as a maintenance treatment modality and its physiologic effects, and one question we had to ask, because the burden of proof on all the aspects of medical safety and physiologic effects rested primarily with us, the investigators carrying out this treatment, was once we had a patient on an oral maintenance dose of methadone and then release him from our hospital because the initial patients were hospitalized, would they injure themselves if they should inject an illicit dose of heroin.

And so with properly obtained crystalline heroin from the Justice Department, who then were the controlling agent, we did studies first on a double-blind basis and then a single blind basis studying the effects of a superimposed dose of heroin and other narcotics such as morphine against a background treatment of methadone, and when the double blind code was broken on each of two study designs, the rather remarkable thing was that these patients maintained at that time on 80 milligrams of oral methadone each day could not perceive what would cost over a hundred dollars worth of heroin on the street subjectively nor could any objective parameters be measured to show that the dose injected had been heroin as opposed to, say, line, which, of course, was also a part of the double blind scrambled protocol design.

And this was important for us to know, and in single blind studies those amounts of heroin were gradually increased to two hundred milligrams of heroin, at that time costing four to five hundred dollars on the street, a price that really no street addict could ever afford to pay in one dose, and with those very high doses, a fleeting narcotic effect would be observed but no more.

And the study subject would say, "It wasn't much, Doctor," but the important thing of this study was two-fold.

No. 1, they were not going to injure themselves or have any severe adverse effect if they should take an illicit dose of heroin but, secondly, it also unearthed the phenomena which has been called blockade or cross-tolerance, which has been a very, very important therapeutic aspect of the high dose methadone maintenance treatment.

Now, we have often commented--

THE COURT: I tell you what. I hate to interrupt you but the plaintiffs are going to have cross-examination of Dr. Kreek?

MR. MORRILL: We have some. We will be relatively brief, your Honor.

THE COURT: We can do one of two things. I have to take the grand jury report which will take a moment. We can try to finish you now or come back after lunch.

Which is more convenient?

I think the reporter needs a break. We will take the grand jury and break until 2:15.

pm

AFTERNOON SESSION

2:20 p.m.

THE COURT: Who have we got for the rest of the afternoon? When we finish with Dr. Kreek --

MR. DUNN: Dr. Lukoff and Dr. Trigg.

THE COURT: You may cross-examine.

MARY JEANNE KREEK, resumed:

CROSS-EXAMINATION

BY MR. BALBER:

Q You mentioned sweating as a side ffect from methadone maintenance treatment?

A Yes.

Q How severe is this sweating? What does the typical sweating methadone patient look like?

A I think I should reemphasize what I said earlier in answer to the questions of Mr. Dunn, that the observation of increased sweating was one made by the patients themselves and it was not one made by myself as a clinical observer.

In some patients one can, in fact, observe sweating, particularly the usual locations, scalp or under the arms, but in others they would be totally indistinguishable by an external observer.

In fact, in a majority of cases you would not in any way be able to pick out the degree of sweating as being atypical of any activity.

It is rather the complaint of the individual. It is not unlike what you can hear from a patient in an endocrin clinic who has mild hyperthyroidism, who has sweating but it is not readily observable to you.

Q It is not disabling?

A No.

THE COURT: You keep using the term disabling. That doesn't -- I assume that sweating would not paralyze somebody.

THE WITNESS: May I perhaps offer an answer?

It does not alter their normal functioning in whatever their daily activities, family, home, occupation or anything else would be. They can perform physical activities, exertional activities, with no atypical response.

Q Dr. Kreek, you testified that you began this research,in what year was it?

A 1964.

Q Have you been engaged in this research continuously since then?

A Yes, sir. Sometimes full time and sometimes part time. In the year 1965, 1966, it was part time. In the other years, it's been full time.

Q You have already testified in some detail about one of your studies involving prospective analysis of a group of patients.

How many separate research studies regarding the side effects of methadone maintenance treatment have you done?

A Regarding the side effects--

Q Medical safety--

A That's a different question.

Medical safety and side effects and physiologic effects, because these three are frequently intertwined and sometimes they are quite individual.

I would say about twelve, although I would have to count them up to be precise on this but my studies have ranged over more than twelve, they ranged over a wide variety of topics.

For instance, in addition to the prospective study on the first group of patients coming into maintenance treatment, I also carried out a cross-sectional retrospective study of some 1435 patients--

Q What is the difference between a prospective and a retrospective study?

A In a prospective study you plan this study in advance of its being carried out. Youdesign a protocol.

In most clinical studies, the protocol is not adhered to with perfection, simply because unlike rats, you can't always draw the blood on a precise day that you plan to, but it is adhered to in the general aspect.

And at the end of this study, the data is collated and analyzed.

In a retrospective study, one decides to go back and look at a question for which there may well be data available but it becomes much more random.

Let me give you an example. I have described the prospective study I carried out. To contrast that with the retrospective study, I did a cross-section look at a group of patients who were admitted to three different units, all of which had several methadone maintenance treatment clinics within their unit:

Rockefeller University, the Bernstein Institute of Beth Israel and the Harlem Hospital.

All the patients who were admitted to treatment over a defined period of time and who stayed in treatment for one month, which was not a constraint in a prospective study, were analyzed in this study and the one limiting factor which excluded any patients from this retrospective study was the lack of availability of their medical charts.

And if you have ever dealt with hospitals you know that sometimes, some hospitals' records are impossible to find because they are always between here and there for an explicable reason.

But in this study--

THE COURT: I am a little lost. I want to give you a full opportunity, Dr. Kreek, to explain what will help us but I think we probably are, have a little scheduling difficulty and why don't you listen to Mr. Balber closely and then stay as close as you can to this questions.

I want to ask, though, and not getting a whole description of the studies, but you said what kinds of studies these twelve were.

You mentioned safety-- what was that?

THE WITNESS: I think, in fact, that's a little bit more germane to our major issue here.

Medical safety, side effects, to ask what were they, and in what percentage of patients do they exist.

The question of whether or not any toxicity could be discerned in patients on chronic high dose maintenance treatment.

The answer to the toxicity in the maintenance patients group was that there was no evidence of any and that's why we have not dwelt upon--

THE COURT: Toxicity meaning--

THE WITNESS: Any adverse effects, demonstrably they are clinically or by biochemical analyses of body fluids.

THE COURT: All right.

Mr. Balber.

Q You said there was no toxicity.

Were there adverse medical-- are there contra indications here of medical safety with the use of high dose chronic methadone maintenance treatment?

A Let me answer your question very tersely and say no.

We were very interested in looking at specific sub-groups of patients after we looked at the general so-called normal healthy individual other than their addiction and the answer is several sub-groups including patients with preexisting liver disease, in patients with preexisting diseases of other types, including coronary artery disease, endocrinologic disease and in patients with a very important concomitant problem which we have mentioned earlier, alcoholic abuse. There was no contra indication to make to maintenance treatment.

So in all of these groups the normally healthy subjects and in a wide segment of patients with a variety of specific abnormalities, there was no contra-indication to treatment.

Q Dr. Kreek, have you discovered any side effects, any side effects in addition to those that you testified to earlier, any side effects that impaired normal everyday functioning of any sort, whether it is walking,reflexes?

A My studies are limited to physiologic and medical effects. My studies have not been those of reaction time, psychomotor function, intelligence testing, or sleep or these things.

Dr. Norman Gordon, Dr. Ann Ho and Dr. Zaks Fink and Dr. Roubicek have all carried out studies in these dimensions.

My studies have been focused on the medical and physiologic effects and the answer to your question is no. In well-maintained individuals on chronic maintenance,other than the things we have mentioned that Mr. Dunn brought out earlier.

MR. BALBER: That concludes my cross.

BY THE COURT:

Q I don't know much about medicine but I am under the impression that medical theories change, in fact we hear the remark that someone can write a text on the field of medicine and it is obsolete by the time it is published.

A Very few.

Q What I'm wondering about here is, are we going to wake up in two years or five years and have the theories and views of methadone different than what I'm hearing today? Is there a possibility of just a change in the experience with methadone, is there a possibility that there will indeed be further information, that kind of thing?

A I think I must answer your question in two parts and it is obviously an extraordinarily important one.

One is,are the medical aspects and the views of the medical treatment going to be altered?

We now are eleven years into treatment and the original patients have gone, in part, some of my patients, my research study patients. I have had a chance to follow these along for those eleven years and have seen both no appearance of unexpected adverse effects, side effects or any alterations of bodily function that can be detected with all the parameters we have available today and, on the other side of the coin,I have seen the majority of these become rehabilitated in whatever we wish to define that, but I think we would all accept common terms "living a normal life" without any substantial abuse and having a family, living in a unit, a unit, working and what have you.

Attitudes, on the other hand, also influence medical care just as they influence many other parameters of life. Attitudes may be acted out in many ways and one of these, of course, ultimately is governmental regulation, availability of treatment in the case of medical care and in the whole area of medicine certainly as well as in welfare and education, there is a tremendous flux going on right now and this is, and I consider this unfortunate since I am primarily an investigator, a scientist, and a clinical investigator, I find it unfortunate that emotion sometimes dictates so much of attitude as opposed to fact dictating attitude.

And certainly emotion as well as in one way and emotion as well as in another way, and when it becomes acted out in a way that contraints are placed upon individuals, then I think the end result can be modified and modified not because of any change in medical philosophy or facts but rather because of contraints that are superimposed on the individual.

What I am saying specifically in the case of methadone maintenance treatment, and I was so pleased to hear your remarks at the intercession point about looking at different groups of people and not lumping everything always in one great big pile; unfortunately regulations of methadone and regulations of some other things have, I think, lumped all patients together rather than looking at different patients as being substantially different from each other. So that there is no distinction made between a patient who has been in treatment, say, for six months and not yet doing well for one reason or another and a patient who has been in treatment for eleven years and a taxpaying citizen like the rest of us who is worried about housing and income tax and what have you.

And this, of course, I think we all as intelligent people would say is incorrect and it is inappropriate and it does put undue constraints on some of these individuals when it means, for instance, that they must come to a clinic twice a week or whatever the regulation now is established at.

And these kinds of constraints, if they persist or if they should become even more stringent with time might, in fact, alter the overall outcome of the treatment modality as a treatment modality, because patients who otherwise were doing very well on maintenance treatment might, in fact, be forced into leaving treatment simply because they could not get to clinics twice a week and keep a job with increasing responsibility and keep a family with increasing responsibility and those patients -- and only time will tell, may or may not have the same ultimate outcome as they would have if they had been allowed to stay on a medical treatment.

If you have a patient with diabetes or with hypertension, or with epilepsy, it is accepted that some of these people need treatment on a chronic basis and in some cases they may need treatment for life, but if because of constraints of incomplete medical care facilites or lack of insurance, they could no longer go for their treatment, their outcome might be different than if they could.

So I don't think the medical philosophy or fact is going to change, which is one of our questions.

THE COURT: That's right.

A I do not thin-- we now have eleven years of evidence which is a lot of evidence as far as adverse effects and functioning and physiology and a lot of studies becoming increasingly sophisticated with time. On the other hand, as far as answering your question about overall outcome, I think, like many things that could change with time.

Q I guess this is outside of your-- what I was wondering-- another thing I was wondering is if you are really relying on-- as a judge or Transit Authority employer, whatever you are dong, if you are relying on the personnel of the methadone maintenance clinics to do this treating competently, to make judgments about employment competently, you wonder if five years from now you will wake up and the zeal is wearing down, people are getting careless.

That's obviously not a professional judgment but is this something that is-- what I would like to know, this has been going on for, on more or less a large scale, for about five years, is that correct?

A That is correct.

1b pm

Q Well, this is just a matter of judgment, whether it is going to keep -- do you think it is being done very well now? Is it in sort of the initial phases? Do you think there is a risk people will get sloppy as time goes on?

A No, your Honor, I think , and this is,again, my opinion. I think it is like the rest of medicine or like the rest of anything else.

There aregoing to be good doctors and not so good doctors. I am sure there are good lawyers and not so good lawyers. I think any profession has those that carry out their task with all the ethics and obligations that that profession bring to them or that job brings to them and others dont. I don't think that this field is necessarily any more or less populated by good or bad. Mr. Dunn and I were discussing last night that one of the real problems about communication between employers and employees is this whole question of communication between doctors and the employer about patients and forgetting about the whole drug abuse area, there are many other paramenters that some doctors and some employers have attitudes or feelings about and some reporting is more reliable and others less reliable. It is an extremely variable thing but I think this is no different. I am not saying anything is going to be perfect, either on the part of the doctors or the patients or the employers but I look upon it as being substantially no different from large scale hypertension clinic or diabetic clinic or anything else.

THE COURT: Thank you very much.

MR.DUNN: Your Honor, may I ask one or two brief questions?

THE COURT: All right.

CROSS EXAMINATION

BY MR. DUNN:

Q Doctor, referring to the article, the paper that appeared in JAMA, February 5, 1973, that you referred to, you observed in that paper, abnormalities in liver function and serum protein tests which were found in 57 per cent and 49 per cent of patients at admission persisted without significant change during treatment.

Would you clarify that finding for us?

A I surely would. I think it is an important point to be brought out.

Heroin addicts on the street usually inject their drug by needles. They use hyperdermic needles and they usually use the same one over repeated periods of time and frequently share them. And there is a very high incidence of transmission of hepatitis, both type A and type B hepatitis by this shared needle.

mild. They were things that would be detected only by extensive examination, biochemical evaluation and in fact the cufoff that I used to define abnormalities in most medical charts in this city considered not to be abnormal but I am very rigorous, I am a liver specialist and I feel that these are mild and everyone else tells me very minimal abnormalities.

Now, 5 per cent of the total group had abnormalities which would have been defined by an internist or a gastroenterologist as moderate to severe and therefore, of some significance and in the prospective study group, those that had that 5 per cent were in all but one case abusers of alcohol; a known toxin to the liver.

Q I just have one or two more questions and I will be extremely brief, your Honor.

To clarify at least to my mind what you testified to, did I understand your testimony to be that essentially there is no significant medical danger or side effects from the use of methadone?

A No significant side effect that would change a person's normal function during long term chronic maintenance treatment. That is correct.

Q There has been no -- you are satisifed that the medical safety of methadone is established?

Now, because of hepatitis that they have shared and because in a few instances of some other viral diseases that infect the liver, a very percentage of people who have had parenteral drug abuse will have evidence of chronic liver disease. Studies have been carried out by myself in methadone maintained patients, by Dr. Barry Stimmel and Dr. Tobias at the Mount Sinai School of Medicine in methadone maintained patients; by Dr. Charles Cherubin and colleagues in former heroin addicts who have been treated by a drug free environment, Daytop; Dr. Sapira and his colleagues at Lexington looking at groups of heroin addicts in that facility, and all of this have made the same observation about heroin addicts coming into treatment, about 50 to 60 per cent having evidence of mild chronic abnormalities of liver function. And all of us have made the observation that these abnormalities persist regardless of the mode of treatment and in my studies and in similar studies we have similarly shown that, for instance, in methadone maintenance, the methadone itself did not create any hepatic liver damage.

Now, the degree of abnormality is the thing that should be focused upon here. These are in 95 per cent of the patients that had abnormalities or 50 per cent of the total group, the abnormalities were extraordinarily

A Yes.

Q Would the same be true of heroin?

A You know, no one, and I don't think anyone ever will, has been able to carry out the study in this country, I surely would not take a group -- I wouldn't any place, take a group of normal subjects and put them on heroin but in this country obviously the heroin that is used is all illicit. The English, as you probably know, in English system one, used any drug to be handed out by the physicians in the treatment of heroin addiction. However, they did know studies of the effects of heroin in this population and the British system one led to a lot of shared needles and frequently abuse. In British system 2 where heroin in some patients and methadone in other patients has been used for the treatment of narcotics addiction, they have observed no problems due to the heroin itself and certainly studies have been carried out of the effects of morphine on a variety of bodily functions in a variety of situations.

Now, morphine is normally not --

THE COURT: Wait a minute, I want to get this clear. You are saying there has been a study performed in England?

THE WITNESS: No. These are anecdotal observations. There is no really good study. The English did not design any prospective study such as mine unfortunately when they started heroin maintenance.

THE COURT: You call it anecdotal. You are describing some --

THE WITNESS: Observation.

THE COURT:: Observations in England?

THE WITNESS: Yes.

THE COURT: About heroin people versus methadone people?

THE WITNESS: Well, heroin people. I am not contrasting it. They used both heroin and methadone.

THE COURT: I think it is of interest -- in other words, if you -- do you know whether if you perform the same tests about the use of heroin, would you come out the same? The obvious conclusion would be, then, the tests you are talking about don't mean a lot for purposes of people like the Transit Authority, they may mean a lot for some purposes but they don't get to the heart of the matter. So what do you find about heroin?

THE WITNESS: Well, I think what has been observed in animal studies and some have been carried out with morphine, not with heroin but with morphine which is congener. Not to be a liver toxin. It has been shown not to cause alterations in blood chemistries in general.

However, morphine and heroin do have some different physiologic effects as usually used in clinical practice or as usually used by the street addict than does methaone.

THE COURT: What are those?

Q Would that not be the result of, or lack of asepsis, carelessness?

A There are two different issued at hand here. One is the drug itself and one is the situation under which the drug is being used. Certainly, when dirty needles are used all kinds of problems occur in street addiction. Hepatitis and infections and what have you.

THE COURT: What are the different effects of heroin?

THE WITNESS: Heroin? The way it is used by a street addict, which is three to four times a day usually, is characterized, since it is a short acting narcotic, by a period of high activity, a period of medium activity and then as a drug finishes its metabolic state, a decreased activity. Functionally this means for most addicts if they have a period of high or euphoria, as he would interpret it, then a period of normalcy or straight as the addict calls it and finally a period of withdrawal sysmptoms. And this cyclic condition, functioning state of the individual is very much correlated and dependent upon the short acting pharmacology of the drug itself. Heroin to morphine.

Methadone has one outstanding characteristic which is different from these two agents and in fact it is this characteristic that made it possible to be used in either the detoxification treatment or the maintenance treatment of addicts, and that is it has a slower onset, a lesser peak effect, and a longer duration of action. With substantial duration of action when used in the doses we use in the maintenance treatment of narcotic addiction for 24 to 36 hours and with this very minimal peak effect and sustained effect there is no functional high or low, no subjective high or low and then when you come to some of the physiology studies and I won't get into detail because these are very exciting to me but I think a little irrelevant to the situation, when you get into the question of endocrine function which is one of the most sensitive functions in the body because it is dependent upon feedback control of brain hormones at two different levels and then a peripheral hormones either at the adrenal gland or at the gonads. This feedback system, in those of us who are on no pharmacologic agents functions in a very elegant way. When a short acting narcotic is pulsed in, there have been studies at Lexington which have shown that some of these hormones may be turned on or off and this, I think we see demonstrated in street addicts, particularly in the female heroin addict. Most female heroin addicts have what we call a menorrhea or else, abnormal menstrual periods. I was taught in medical school it was probably because they had chronic venereal disease and this is an independent result sometimes of chronic veneral disease but I think one of the most interesting things for us and in a way a very important observation was when these women who had several years of abnormal periods on the street came into treatment with high dose methadone maintenance, which one year over 90 per cent of these women who were child bearing age and who had uterus -- who had not had a hysterectomy began to have normal menstrual cycles again and their whole endocrine function returned to normal. It does show one area where there is a difference psychologically between a short acting and long acting.

THE COURT: I suppose the thing that is quite an important distinction -- I think you have covered it.

MR. DUNN: I have at most three questions. They are directly related to something the Court has brought up.

Q Just very briefly, Doctor, as a researcher, do you have an opinion as to the medical safety and possible side effects associated with opium?

A No, I have had really extraordinarily limited --

THE COURT: I am going to sustain -- I will not permit that question. Do you have anything else?

MR. DUNN: Yes, I do, your Honor.

Q Was opium at one time used much like methadone is used today for treating alcoholics?

MR. BALBER: Objection, your Honor.

THE COURT: Sustained.

MR. DUNN: Your Honor, as an offer of proof I wanted to establish that with respect to the Court's question as to whether in five years methadone would still be considered the same, as a treatment of choice for heroin addiction, that opium at one time was the treatment of choice for alcohlism and at some point in time, after this had been a widely used treatment for alcoholism, the medical profession reversed itself and rejected this mode of treatment.

THE COURT: If we are going to get into that, that requires something beyond what we can do in five minutes with Dr. Lukoff having sat here 45. It would mean getting into -- I think that -- I don't doubt it may be a legitimate subject of inquiry. It involves finding out some valid comparison between what is going on with methadone now and what was going on with opium then. Did opium as used then have the same reputation and effects as methadone now. We cannot cover that in five minutes.

MR. DUNN: The only thing I wanted to establish from the witness was ask her if she was aware of the modality of treatment, whether she would recommend the treatment now or reject it now and why.

THE COURT: You can't get into that in the brief time. You will have to cover that with some other witness. We have to have some kind of a schedule.

MR. DUNN: It maybe that the witness has no opinion on it, your Honor.

THE COURT: If you want to bring that out -- look, is this something you know about? I am worried about a schedule.

THE WITNESS: It is something that is as irrelevant, I feel, as discussing leeches that were formerly used in the past for blood letting. We are talking about the whole practice of changing medical treatment. We can discuss this for days and days. Histories of medicine have been written on this. Certainly with advanced scientific knowledge we have made tremendous progress, I certainly hope in all these areas and there are very precise reasons to say there is no analogy whatever between opium treatment for alcoholism and methadone treatment for drugs.

Methadone and heroin are generally in the same class, not at all very different in their morphologic specificity whereas opium and alcohol have no chemical similarity and no physiologic similarities.

THE COURT: Thank you very much, Doctor.

MITCHELL S. ROSENTHAL, called as a witness by the Court, being first duly sworn, testified as follows:

MR. DUNN: May I request the Court advise the witness.

THE COURT: The witnesses appearing now are really pursuant to my request.

You were probably advised there were people that did not want to appear because they did not want to take sides in a partisan way.

Your appearance here does not constitute a partisan appearance obligation. You are here and both sides will question you and I will question you.

Are you going to lead off, Mr. Dunn?

MR. DUNN: Yes.

DIRECT EXAMINATION

BY MR. DUNN:

Q Do you have a copy of your curriculum vitae?

A I do not.

MR. BALBER: We have a copy to save time.

MR. DUNN: Dr. Rosenthal has provided us with a copy of his curriculum vitae which I offer as Defendant's Exhibit ~~ZZ~~ 55.

THE COURT: It is received.

the Police, these being the criteria for success,dependent on the time they have been in the program.

An approximate summary would be that if somebody had spent less than three months in the program, there would be practically no change.

Those spending between three and eleven months in the program, there is approximately a 50% improvement.

Those spending between twelve and eighteen months in the program, there is a 70% improvement and where they are spending more than eighteen months in the program, there is a 90% success.

Q Is there a prototype of patient that presents himself to the program?

A No. In fact, what is important is that we really have tremendous variety of patients by any criteria, whether we are talking about sociodemographic criteria or psychological criteria.

The one common denominator of all of those patients based on the aggregate of all our data is that they are all psychologically disturbed.

If we do examinations, psychological examinations on that group of patients and then give those psychological test results to a group of experts, they would have difficulty in distinguishing those test results from the test pm THE COURT: Pursuing that, what has the problem been if you have 40,000 methadone patients in New York City?

THE WITNESS: Of the 40,000 methadone patients in New York City, it would be very difficult to determine what percentage of those people would be good solid employment risks in any area.

THE COURT: Why is that?

THE WITNESS: Because of the 40,000, you are going to have a large number of those patients who have been in the program for a year or less. That group of people would not even have built a long enough tolerance to methadone to be very good employment risks and I think there would be general concurrence among methadone physicians that this group of people were still in an early phase of treatment and in fact they would not be referred for employment.

Then you have many who are in for that period of time and longer who are continuing to abuse other drugs at the same time as they are getting their methadone and I think one of the issues that we raised in this article that counsel was referring to was the fact that there is a very high incidence in general of cheating, meaning, the taking of other drugs while one is in a methadone program.

THE COURT: You say high incidence. Two questions come to mind: Is there any way that you could suggest in general terms how much that is and secondly, can it be detected?

THE WITNESS: Yes. It has been studied. The best studies on it were done by Dr. Carl Chambers and Dr. Taylor in Philadelphia and are cited in the bibliography in our argicle in science.

THE COURT: When did they make those studies?

THE WITNESS: They did those studies, I think in 1970 and 1971.

There have been subsequent studies by other experts and there is a fair consistence on this that the cheating instances is in the magnitude of some 70 per cent.

THE COURT: 70 per cent relating to what?

I would like to do this, and I think this follows up testimony which we have had in the recent day or so. Separate the people who have been in these methadone programs for under a year as opposed to those people who have been in overa year.

The 70 per cent cheating, that range. Are you thinking of the whole methadone group or just what?

THE WITNESS: As I recall, one of the important findings in that study was that the incidence of cheating did

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Q The methadone witnesses we have heard, they recognized there are lots of problems to be handled besides the physical taking of a dose of methadone and they have rehabilitation programs.

They do not ignore the fact that there are other factors in the drug problems besides the physical problem.

A Your Honor, if you look more carefully at what the methadone clinics in this city and even in this nation do, the majority of them do very little other than supply the methadone.

So that while there is a conceptual recognition that there are other problems and so forth, most of them in operation provide little more than the methadone itself.

Q Can you be more specific about the ones in New York City?

A Well, the largest series of programs in New York City would be covered, if we looked at the City's operated methadone programs, and the Beth Israel complex -- in both of those groups there is little other that is available to the patients other than the dispensation of methadone.

Q In the Beth Israel and the City programs?

A Yes.

Q The reason I am stopped-- that is very much different from what I have been hearing.

Are you saying that the Beth Israel clinic does not, their programs do not have rehabilitation?

Don't they have counselors?

A There are some counselers available. This group, the Beth Israel group, really began its work with the premise that the condition of heroin addiction was almost a metabolic condition and that if in fact one took care of the heroin hunger, the drug craving,and supplied that missing X substance, much as one might supply insulin for a diabetic, then the problems would be taken care of.

Once you start with those premises, then the need for the delivery of mental health services in those clinics is really of -- very, very minimal. So that I think that if you sent a group of management analysts or program analysts into the clinics and you said, "Now, what is the activity that goes on here in a 24-hour period?" you would see that the bulk of the activity was really the giving out of methadone and that little clinic energy was really attending to the other problems that patients have.

Q Well, when you say little, you feel not enough?

A Yes. In general, I feel that, (1) there has not important because the same drug taken intravenously will give exactly the same kind of orgastic euphoria that heroin will, but taken orally, that patient will come to a point in time when he experiences very little, relatively little euphoria.

At that point the methadone people feel that the patient is then in a position to go on about the -- his other problems thathis drug needs, so to speak, are ~~taken~~ care of and then he can begin to think about working or getting job training or doing some other things instead of running about trying to support himself to stealor raise money for his next dose of heroin.

Q If he is detoxified, as he can be from what you say, then his drug needs after that are really more of a mental thing, aren't they?

A Well, that is exactly correct, your Honor, and that is the basis on which those of us who approach this problem psychologically begin our work. In other words, it is no big thing to get somebody drug free. Practically all addicts have been detoxified and have been drug free at given periods. The work is to develope new inner resources and new ways of people understanding themselves and learning how they deal with anger, how they deal with fear, how they deal with loneliness, how they deal with other inner personal problems that generally cause them to use drugs.

CURRICULUM VITAE

Beny Jene Primm, M.D.
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New Rochelle, New York 10801
(914) NE 2-2199

EDUCATIONAL BACKGROUND

West Virginia State College
Institute, West Virginia
B.S. Education, 1947-1950

University of Heidelberg
Heidelberg, Germany
1953-1954

University of Geneva
Geneva, Switzerland
M.D., 1954-1959

INTERNSHIP

Meadowbrook Hospital
East Meadow, New York
Rotating, 1960-1961

RESIDENCY

Meadowbrook Hospital
East Meadow, New York
Anesthesiology, 1961-1963

CREDENTIALS

Licensed to practice medicine
in the State of New York
License No. 86686
State of New Jersey
License No. 027460
State of Massachusetts
License No. 36204

Fellow
American College of Anesthesiologists
1965

LANGUAGES

English - Fluent
French - Fluent
German - Read

EMPLOYMENT BACKGROUND

1969 -

President and Executive Director
Addiction Research and
Treatment Corporation
22 Chapel Street
Brooklyn, New York

Responsible for overall operations of the Corporation including treatment, research and administrative functions. Directs program planning and the development of corporate policies and procedures. Conducts or participates in news conferences, TV appearnaces, and meetings with representatives of government, business, labor, and community organizations. Represents the Corporation at meetings of City, State and Federal agencies and at conferences of various professional organizations. Guides the operations of the Medical Department and directs specific attention toward the development of new areas of research and the collection of pertinent data.

2/71 -

Hunter College, School of Social Work
120 East 79th Street
New York, New York 10021

Assistant Professor

1969 - 1971

Co-Medical Director
M. J. Lewi College of Podiatry
New York, N. Y.

Served as Director of Clinical Medicine. Lectured on the relationship between clinical and podiatric medicine.

EMPLOYMENT BACKGROUND

1968 - 1969

Director of Narcotics Control
Hospital Orientation Center (HOC)
Harlem Hospital Center
Columbia University
New York, New York

Developed the Hospital Orientation Center. Headed a team which was concerned with developing a system for the detection and treatment of drug abuse among patients and staff of Harlem Hospital Center. Advised the hospital's Medical Board regarding the problem of drug addiction and abuse within the hospital complex.

1966 - 1969

Director of Professional Medical Services and Director of Anesthesiology
Interfaith Hospital of Queens
Jamaica, New York

Responsible for the supervision of all medical and nursing staff as well as clinical services. Developed a major drug program including detoxification center and therapeutic community. Integrated this program with the current Economic Development Program of the National Economic Growth and Reconstruction Organization (NEGRO). Also, established a new Department of Anesthesiology and directed all functions of that department.

1966 - 1968

Co-Director of Anesthesiology
Whitestone Hospital
Queens, New York

Shared administrative responsibilities and was involved in reorganizing and restructuring of the department.

EMPLOYMENT BACKGROUND

1966 - 1969	Associate Anesthesiologist Harlem Hospital Center Columbia University New York, New York Served as part-time member of the Department of Anesthesiology, specializing in providing treatment for addicted and drug abusing patients.
1964 - 1967	Director of Anesthesiology Oyster Bay Hospital Bayville, New York Responsible for the administration of the Department of Anesthesiology and the development of new operating procedures.
1963 - 1964	Assistant Anesthesiologist Harlem Hospital Center New York, New York Established Cardiac Emergency Resuscitation Team and developed equipment and training staff for this unit which included all medical, nursing and ancillary services.

BOARD OF DIRECTORS

1970 - 1971	Board of Directors Provident Neighborhood Comprehensive Health Center Brooklyn, New York
1969 - 1971	Board of Directors Confrontation, Inc. New York, New York Acted as member of Board of Directors and Medical Consultant to drug program run by ex-addicts. Assisted in the establishment and development of a comprehensive treatment program for that organization.

BOARD OF DIRECTORS

1970 -	Chairman Sub-Committee on Narcotics Health Task Force New York Urban Coalition
1969 - 1970	Board of Directors People's Program on Narcotics New York, New York Assisted in the establishment of a Harlem based drug program run by ex-addicts. Acted as Director/ Medical Consultant for the program.
1968 - 1969	President Council of Community Voices on Narcotics New York, New York Assisted this coalition - which developed into the present Harlem Drug-Fighters Organization - in the development of a coordinated approach for dealing with drug addiction. Negotiated for funding of $750,000 from the City of New York for strengthening this coordinated effort. Was involved in the on-going organization-and mobilization of a broad spectrum of grass-roots organizations.

CONSULTANTSHIPS

1972 -

Consultant Expert
Special Action Office for Drug
Abuse Prevention
White House
Washington, D. C.

Consultant to the Office of the Director with responsibilities for evaluating and rendering technical assistance to federally funded addiction treatment programs throughout the nation as well as those operated by the U. S. Armed Services abroad. Functions include analysis of existing programs and design of new treatment systems in cooperation with the Department of Defense, the Veterans Administration and the Department of Health, Education and Welfare.

1970 -

Narcotics Consultant
Social Consult, Inc.
New York, New York

Functions include design and evaluation of drug abuse treatment programs nationwide. Also, provide technical assistance in the development of new treatment approaches and organizational structure.

1969 - 1973

Medical Consultant
Honorable Thomas J. Mackell
District Attorney
Queens, New York

Provide the District Attorney with medical expertise in matters related to narcotics addiction and drug abuse.

1969 - 1971

Narcotic Consultant to Executive Board
Narcotics Guidance Council
New Rochelle, New York

Advised on the development of school policy regarding drug abuse treatment and prevention efforts.

CONSULTANTSHIPS

1969 - 1970	Medical Narcotic Consultant Board of Education District #4 New York, New York Developed the "Save the Addicted Student Population" (SASP) Program operating out of the Community Education Centers Program.
1966 - 1968	Consultant Anesthesiologist Hamilton Avenue Hospital Monticello, New York Acted as consultant to nursing staff and assisted in the development of new operating procedures. Responsible for administering anesthesia in special and difficult cases.
1964 - 1968	Consultant Anesthesiologist Veterans Memorial Hospital Ellenville, New York Acted as consultant to nursing staff and assisted in the development of programs for increasing the department's efficiency. Was responsible for administering anesthesia in special and difficult cases.

MEMBERSHIPS

1972	Member White House Briefing Team on the Administration's Accomplishments in the Area of Drug Abuse
1972	The Committee on Problems of Drug Dependence The National Academy of Sciences National Research Council

MEMBERSHIPS

1972	President Nixon's Advisory Council on Drug Abuse Prevention
1972	Member Carbon Dioxide Treatment Evaluation Team Pennsylvania Medical Society Lemoyne, Pennsylvania
1972	National Ad Hoc Committee for the Development of Drug Abuse Prevention, Treatment and Rehabilitation and Establishment of National Training Center for Drug Abuse Washington, D. C.
1972	Speaker First Caribbean Seminar on Drug Abuse and Its Problems St. Thomas, Virgin Islands
1971	Member and Trainer President Nixon's Drug Evaluation and Technical Assistance Team to Viet Nam
1971 - 1973	Member Drug Abuse Committee National Medical Association
1971	Adult Member Narcotics Task Force White House Conference on Youth Estes Park, Colorado
1971	Speaker 102nd National Convention of the American Medical Association Atlantic City, New Jersey

MEMBERSHIPS

1970-1972	Member Provident Medical and Clinical Society Brooklyn, New York
1969-1970	Community Narcotic Advisory Committee Senator Charles Goodell New York, New York

MILITARY

1950	Commissioned 2nd Lieutenant United States Army
	Served in 82nd Airborne as Platoon Leader, Executive Officer and Battalion Intelligence Officer
1953	Medical Retirement 1st Lieutenant U. S. Army Paratrooper

PUBLICATIONS

March, 1974	Electrophysiological and Pharmacological Studies of Narcotic Substitutes: Tyramine and the Central Effects of Methadone Hydrochloride. Authors: E. E. Inwang, Ph. D., P. E. Bath, MD and B. J. Primm, MD. Submitted for: Proceedings of the 1st National Drug Abuse Conference, March 30-April 1, 1974 Chicago, Ill.
March, 1974	Minority Training Issues. Presentation at the National Conference on Drug Abuse, Feb., 1974 - Concerned, Vol. 1 No. 8, March, 1974.
Jan., 1972	An Experimental Program for Providing Incentives to Successful Methadone Patients. Authors: P. Baldridge, M. McCormack, A. Zarrow and B. J. Primm, M. D. Submitted for the 4th National Conference on Methadone Treatment, San Fran., California, January, 1972.
Jan., 1972	Ancilliary Services in Methadone Treatment: The Bedford Stuyvesant Experience. Proceedings, Third National Conference on Methadone Treatment, National Institute of Mental Health, San Fran., Calif. January, 1972

PUBLICATIONS

1972	A Comparison Study of Thin-Layer Chromatography Urinalysis Results. Authors: C. E. Riordan, M. D. F. Slobetz, S. Wall and B. J. Primm, M. D.
1972	Methadone Is No Answer, 34th Annual Scientific Meeting of the Committee on Problems of Drug Dependence, National Research Council, Ann Arbor, Michigan, May, 1972
1972	Pseudoheroinism, International Journal of Addiction, 1973
1971	Public Health and Safety. Presented at the International Conference on Cities, Indianapolis, Indiana, 1971

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BENY JENE PRIMM, called as a witness on behalf of the defendant, being first duly sworn, testified as follows:

DIRECT EXAMINATION

BY MR. DUNN:

Q Dr. Primm, I show you Defendant's Exhibit UU and ask if this is an accurate representation of your background, training and experience.

MRS. DuBOIS: Your Honor, should the witness be sworn?

THE COURT: I thought he had been.

THE CLERK: He has been sworn.

MRS.DuBOIS: I am sorry, I did not hear.

THE COURT: Go ahead.

MR. DUNN: Mr. Reporter, would you repeat the question, please?

(Question read)

A Yes, it is.

MR. DUNN: I offer this.

MRS. DuBOIS: No objection.

THE COURT: Received.

xx (Defendant's Exhibit UU received in Evidence)

Q Dr. Primm, what is your principal prosition at this time?

A I'm the Executive Director of the Addiction Research and Treatment Corporation.

Q How long have you been so engaged?

A Since October 1969.

Q Can you tell us, Doctor, what the Addiction Research and Treatment Corporation is?

A It is the largest nonprofit multi-modality treatment program for the treatment of addicition in the country.

Q What is the structure of -- is it ARTC; is that how it is referred to?

A Yes.

Q What is the structure of ARTC? Starting with the board of directors working down.

A We have a board of directors that I directly relate to as the Executive Director. I have under me an administrative director, and beneath him a structure -- there are approximately seven different departments, namely, Education, Legal, Job Development, Social Services, Medical, Patient and Staff Education, and strictly -- one of strictly Administration. I think that is seven in number.

Q What is your total patient census, Doctor?

A As of today, approximately 1,769 patients.

Q How many clinics do you operate?

A We have three in Harlem and three in Brooklyn at the present time.

Q Do you have any in Manhattan?

A Well, Harlem is in Manhattan.

Q Can you describe the staffing of each clinci, Doctor?

A Our program is set up where we have what we call satelites or treatment centers or clinics that treat approximately 250 patients in each clinic, and the structure of each one of these clinics is just like the structure of a corporate body.

Where we have a board of directors to the corporate body, we have a community advisory board to each satelite within that district in which it is located.

THE COURT: You are referring to the six clinics?

THE WITNESS: Exactly.

THE COURT: And each has an advisory board?

THE WITNESS: A community advisory board.

Each one of these clinics operates independently.

They have a clinic supervisor, they have each department represented: Medical, Social, Educational, Job Development and Patient and Staff Education, and a legal person within that department; and, of course, the other one for Administration.

THE COURT: Each of them basically has the seven types of people or divisions that you mentioned earlier, right?

THE WITNESS: Exactly.

We also have what we call an interdisciplinary team, an IDT within each one of these particular satelites. This IDT is composed of a physician, a social service person, either a counselor or a supervisor, a job developer, and generally someone administrative from that satelite to make any determinations on the patient's progress and well-being.

THE COURT: In each clinic?

THE WITNESS: In each clinic.

The IDT or interdisciplinary team makes determinations to whether a patient remains on the program once he has violated any of the program's policies or regulations.

We place -- the IDT has a responsibility of putting people on probation or recommending the discontinuance in the program if behavior has been so recalcitrant that it is supportable by the appropriate policies.

In some instances we give both methadone and drug-free therapy or chemotherapy and psychotherapy, as I like to call it --

Q Before getting into that, Doctor, can you tell us what the funding is of your program?

A The funding is from the National Institutes of Drug Abuse, which is formerly the National Institute of Mental Health. It's a matching grant kind of situation where the City of New York in the first year would supply ten percent, and in succeeding years will take on a bigger bite of whatever that funding process is.

The City of New York -- the conduit of funds comes from the Addiction Services Agency, and it votes through the Board of Estimate, of which you know the structure of that.

THE COURT: Right now, you get both City and Federal funds, right?

THE WITNESS: Exactly.

THE COURT: And the Federal funds come from the National Institute of Drug Abuse, right?

THE WITNESS: Exactly.

THE COURT: Then the City funds again from what institute?

THE WITNESS: The Addiction Services Agency, or which they have tax levy funds, and it's funneled through ASA to monitor those funds.

THE COURT: Do you get any from the State Government?

THE WITNESS: Not at all.

THE COURT: What is the total of the funds you are getting now per year, roughly?

THE WITNESS: Around $5,000,000. We have some special projects.

THE COURT: Let me just break that down.

Can you tell me how much of the five million you are getting from the City and how much you are getting from the Federal Government? Approximately.

THE WITNESS: You know, I'm testifying here and I think it would be very difficult unless you will allow me to bring in, you know, my whole fiscal report and read from it, and I'm not prepared to do that at this point.

I would say at the present time approximately -- and I want that clear on the record -- maybe 30 percent of our funds come from tax levy funds in the City of New York.

THE COURT: And the other 70 from the Federal Government?

THE WITNESS: Yes.

THE COURT: I understand it is an approximation. That is all I was asking.

THE WITNESS: We do have other grants to do special projects, and those grants also come directly from the Federal Government with no matching funds whatsoever from the City of New York. One in a policy drug abuse program, which is half a million dollars; another one to set up a training center, a vocational rehabilitation center in Brooklyn, which comes also to approximately a half a million dollars yearly.

THE COURT: What were those two? You have got --

THE WITNESS: A policy drug abuse project that comes directly from the Special Action Office of Drug Abuse Prevention, or SAODAP.

THE COURT: What is the other one?

THE WITNESS: The other one is a skills training and vocational rehabilitation center that is in Brownsville, in Brooklyn. That's just beginning to start up. They've just gotten the money for bricks and mortar and the training funds come through the conduit of the Addiction Services Agency, but they are not tax levy funds, they are Federal funds.

THE COURT: Is this a half million dollars a year or just a total of a half million dollars?

THE WITNESS: It is a half million dollars approximately a year including moneys from the Department of Commerce for the bricks and mortar part of the operation.

THE COURT: And the poly drug abuse project is also five hundred thousand dollar a year?

THE WITNESS: Exactly, which, if one looks at the number of clinics and things that we run and instead of them being say, six or seven in Harlem and Brooklyn, it becomes a few more because of the special kind of projects that we also run under the aegis of ARTC.

Q You started before, Doctor, describing the various treatment modalities that are utilized by ARTC. Will you tell us what modalities were used and what percentage of your patients are in each of the modalities?

A We have chemotherapy and psychotherapy. We have a blend of the two. We have completely drug-free therapy.

THE COURT: Chemo? How do you spell that?

THE WITNESS: C-H-E-M-O.

THE COURT: What is that?

THE WITNESS: That would be the use of methadone, the use of L alpha acetymethadol, a long acting methadone cogener that we are also looking at.

THE COURT: Basically it is methadone, the chemotherapy?

THE WITNESS: It is.

THE COURT: And then you have the psychotherapy?

THE WITNESS: Exactly. Both individual and group psychotherapy and we can employ them individually or in conjunction with one another.

THE COURT: Then you mentioned drug-free?

THE WITNESS: Drug-free.

THE COURT: Go ahead.

Q How, if at all, Doctor, does the treatment accorded a patient in ARTC differ from the treatment accorded a patient, if you know, at the Beth Israel program?

A I do not know the intricacies or the treatment pattern they use at Beth Israel but I can say that our program offers the most sophisticated and wide range of treatment more than any other program in the country.

Q Are you familiar with the dosage pattern followed by Beth Israel in their methadone maintenance treatment program?

A Yes, I am.

Q Focusing on that aspect of ARTC. That would correspond to the methadone maintenance treatment program at Beth Israel. Does your dosage pattern vary in any way?

A Considerably.

Q Or is it distinguishable from the pattern followed by Beth Israel?

A Considerably different.

Q Could you describe for us what Beth Israel's pattern is, what your pattern is and what the distinction is?

A In the jargon of the profession of narcotic rehabilitation, I often speak of the Beth Israel or the Dole method of administering methadone as classical. I like to talk about what we do at the Addication Control and Research Program as being neo-classical in that the Dole method which is a classical method as people placed on methadone ad infinitum and because it was based on the metabolic theory. Not only that, their dosage range would be anywhere from 60 to 120 milligrams of methadone given in a daily dose orally, ad infinitum, whereas my program and all of my Harlem patients which number about one thousand at this time and I only have four patients over fifty milligrams of methadone giving them daily dosages. I do not feel that one necessarily has to have methadone ad infinitum because we do not completely embrace the metabolic theory of addiction.

THE COURT: What is the metablic theory of addiction?

THE WITNESS: That once a person has become addicted to an opium-like substance, that there is something lacking within his system that is caused by this addiction that must be replaced by a like substance and whether it be synthetic of one of the derivatives of opium itself.

Q Is this the theory that is propounded by Dr. Dole?

A That is the classical theory of methadone maintenance.

Q Do you agree or disagree with that theory?

A I disagree with that theory and when I started the program in 1969, that is why we started to get involved deeply into research to find out whether that theory was indeed true or whether it was not true and we have felt that the theory had some holes in it and some of our conclusions, preliminary conclusions are that the theory just does not hold true at all.

We will soon be publishing offically our findings.

Q Did you state, Doctor, the number of patients that you have in ARTC on the various types of programs? Could you give us a breakdown of the number on each of the programs, approximately?

A Approximately 70 percent of our patients are on chemotherapy or methadone or LAAM. That is an experimental substance that we have been given a special grant to look at its efficacy in our patient population.

THE COURT: Let me get the name.

THE WITNESS: L alpha acetymethadol meaning that the substance is --

THE COURT: This has the initials LAAM?

THE WITNESS: That is correct.

THE COURT: And without getting too technical, what is the basic difference between that and regular methadone?

THE WITNESS: Pharmacologically?

THE COURT: What does it do that is different?

THE WITNESS: It is longer acting. In other words, the duration of action of the substance when it is taken if for a longer period of time. Anywhere from 48 to 72 hours whereas methadone would last anywhere from 24 to 48 hours depending on the metabolism of the individual to whom it was given.

THE COURT: Any other difference?

THE WITNESS: It has some different pharmacological properties. It might have a greater affect on the lowering of the blood pressure. It may have a greater affect on dimishing the pulse rate. It may have a much more considerable sedative affect if not given under close scrutiny. At this point it is just a highly expermimental substance that we are looking at to see if it could replace methadone and cut down on some of the problems of the illicit distribution of the substance. In other words, a patient would have to come in for this substance say three times a week or even twice a week whereas he has to come in for methadone almost daily and with LAAM, there would be no take-home privileges whatsoever. It would cut down on the illicit distribution of methadone in the programs, illicit programs.

THE COURT: You started to give us the breakdown. You said 70 percent were on chemotherapy.

THE WITNESS: Chemotherapy would be methadone or LAAM. Thirty percent of the patients would be drug-free involved in group psychotherapy and individual psychotherapy.

The 70 percent of the patients involved in chemotherapy also receive individual and group psychotherapy. One-hundred percent of the patients receive counseling -- I like to call it common sense counseling. Approximately 30 percent are involved in some educational pursuits and 35 percent of our patients are gainfully employed.

Q Does ARTC engage in resource activities other than what you described, Doctor?

A Unquestionably. The Yale Medical School evaluates the impact of the ARTC program on the patients from specific health areas that we serve. The Harvard Law School, and a team was headed there by Jim Vaughnberg, are involved in determining what kind of impact does this make on the patient population from the catchment area which we serve and what type of impact does it make on the criminal behavior and crime in the areas which we serve.

The Columbia School of Social Work under the heading of Dr. Lukoff, looks at the social impact of the family, in terms of merchants, etc.

ARTC is possibly the most research oriented program in the country. There has been more printed about it than any other program in the country. I must say both derogatory and in a commendable fashion also.

Q As a result of the research conducted at ARTC, was a patent applied for for a drug by the name of dioxycycline?

A It was at one time.

Q Can you tell me what the significance of that drug was?

A We had an experimenter who felt that this substance could be used for detoxification of addicts and it didn't have any opiate kind of product whatsoever. We later found that this substance was not affective for that particular use and patended it just in case other experimenters would look at it and maybe come up with something new about the substance. That has been some two years or three years ago.

Q Is the research an ongoing effort at ARTC, not on this particular drug, but generally?

A Yes.

Q Have you encountered patients with multiple drug abuse problems?

A Unquestionably.

Q Are you familiar with the report of Drs. Chambers and Taylor,the report of 1970 which they reported 97.6 percent of patients on the program that they had studied who had been on the program for at least 24 months had during a one-month period abused at least once an illicit drug?

A Yes.

Q And the report of Dr. DuPont similar to the Chamers and Taylor study reporting that after 14 months of treatment, he found patients abusing illicit drugs at least once in a one-month period total 55 percent of the patients that he studied in his program?

A I don't think Bob talked about abuse. He talked about usage.

THE COURT: DuPont?

THE WITNESS: Yes.

A (Continuing) Russell Taylor and Carl Chambers also talked about use of the substance. Of course, any use of a substance, which is not prescribed could be considered an abuse. I do not necessarily consider it an abuse.

Q Making that distinction and you using the word use rather than abuse, have you any idea as to the prevalence, if at all, of illicit drug use by the patients in ARTC both in the drug-free program and in the chemotherapeutic program?

A I think we have to start at a different point.

Most of the people that become drug-free at ARTC, the majority of them have been on methadone. In other words, they have gone from methadone to abstinence and then are drug-free.

There is another group, a very small proportion of the 30 percent that I mentioned, approximately 2 to 5 percent of that 30 who come on the program initially drug-free and remain drug-free. So, with that kind of preface to the answer to your question, I will try to answer it.

During the first eight weeks in our patient population at ARTC, we find that our patients do use illicit opiates and drugs of other kinds. That generally tapers off where we might see intermittent but rarely, intermittent substance use for the next six months. The majority of our patients after that time will occasionally show what is spoken of as dirty urine for approximately three months to the end of the year.

The most common substance of abuse --

THE COURT: Can you pause for a minute.

Would you read back the last few sentences.

(Read back)

A The most common substance that is used is, of course, alcohol.

THE COURT: Does that show up in the urine analysis?

THE WITNESS: Not at all.

THE COURT: Go ahead.

A (Continuing) We will find, of course, quinine which we feel is indicative of illicit heroin taken even though we do not find morphine excreted in the urine. We also find sometimes doriden, the chemical name glutethemide, bartiturates and occasionally amphetamines.

My patient population, however, is not, and I want it very clear, is not a typical patient population. The profile on my patients is about an average of 31 years of age, a tenth grade education, a history of seven years of incarceration --

THE COURT: Average 31 years of age, tenth grade education, seven years incarceration.

Go ahead.

A (Continuing) -- and ten to eleven years involvement in drug abuse. They generally start at age 21 and are considered, by the time I get them, as very hard core drug abusers. Our patients are 85 percent black, 10 percent Puerto Rican and 5 percent white and it is considered by most of my colleagues and experts in the country of being the hardest of the hard core population of drug abusers in this nation.

So, they are not characteristic or typical of the addict that one might see in other programs in the City of New York or in other parts of the country.

So, I don't think when we began to talk about their substance use after starting treatment, that it can be applicable in a generic sense to other patient populations, unless that patient population would have the same profile as the ones that I serve.

Q Given the profile that you have just described to us, Doctor, do you feel that a reasonable goal of treatment for your patient population would be eventual detoxification from methadone?

A Well, it has been said by a number of experts that if you have abstinence as an initial goal, that your program is doomed to failure.

We treat our patients with that philosophy in mind. We think that any patient who comes to the program can look to become abstinent at his own pace, whether that abstinence be from methadone or whatever substance he might abuse.

As a consequence, we have a pretty good cooperative effort from our patient population and as he moves from once stage to another, we allow him to set his goals and help him to work towards that goal that he has set and our program is geared to the relative behavior of the individual that is involved.

I hope that answers your question.

THE COURT: Going back, you outlined the results in a general way as far as drug abuse through the first year. How about after a year, is there a different pattern?

THE WITNESS: Indeed so.

THE COURT: Let us say after a year.

THE WITNESS: We notice less and less involvement and, sometimes, but not all the time, a cessation of involvement in illicit substances.

THE COURT: Are you including alcohol as an illicit substance?

THE WITNESS: I am not including alcohol.

I think, your Honor, you have to remember that alcohol is a substance that a number of people abuse within our society or use and that is an acceptable substance of use and that people who seek to change, to have some change of their psycho active behavior will indeed use this substance, just like the normal population does, and the addict population is no different.

So, when we think of them drinking, we can think of our colleagues on the Bench drinking, my colleagues in medicine drinking. It is the same kind of a drinking.

THE COURT: Is it any worse among methadone patients than among other people?

THE WITNESS: It is no worse than the alcoholics in the business world or judicial or medical professions.

THE COURT: I accept that an alcoholic is an alcoholic within reason but I am talking about the frequency of finding alcoholic problems, drunkennessor however you want to say it. Is a methadone patient more prone to do that, to drink heavily so he can't perform very well? Is he more apt to do that than the seventeen-hundred other people?

THE WITNESS: I don't think his goal is one of not being able to perform when he begins to drink.

THE COURT: I am just talking from your observation. Is a methadone patient statistically more apt to have drinking problems than other people that aren't on methadone?

THE WITNESS: It is a difficult question for me to answer. I could talk about it for a moment if we have the time.

THE COURT: Sure.

THE WITNESS: First of all, you have a population of people who have been involved for a considerable period of time in drug abuse behavior and drug use behavior. These people are concentrated in a specific program. In other words, if you took all the people that abuse say tranquilizers and put them in one program, these people would have a greater facility towards abusing another substance, and that would include any other mind altering substance.

With that kind of preface, indeed so. I think you will find a greater proportion of the people involved in a program that use chemotherapy like methadone involved maybe with drinking but not to the point of drunkenness in which you described where they would be nonfunctional.

As a matter of fact, it is rare that we see patients within our facility drunk. It is no different than what we see normally with society of people that are drunk.

We have in our program, an alcohol treatment program that we started up because we saw that patients who got off heroin and got on methadone and were still idle and still had no jobs and still were immobilized and politically and economically and socially and racially and every other kind of way, I am beginning to wonder is alcoholism sort of therapeutic for their behavior rather than they are just abusing these substances and are we not, as people who are not abusers of substances putting our life-style on a group of people who have many more major problems that they might have to resort to that kind of behavior like many middle class people that take meprobamate or valium or librium that is prescribed by physicians like myself.

I am not so sure that that isn't a very acceptable behavior pattern to follow, that is, one of imbibing.

THE COURT: Let me see if I understand you. You say if you take a group of seventeen-hundred or whatever number of methadone patients, you might have somewhat more drinking than you would if you just took seventeen-hundred other people in society?

THE WITNESS: Randomly sampled individuals.

THE COURT: Although if you took seventeen-hundred people who were on tranquilizers, you might have a lot of drinking there too because their frame of mind is to seek something in some narcotic.

THE WITNESS: Not narcotic, but something --

THE COURT: Something aside from listening to music or playing basketball.

THE WITNESS: Exactly.

THE COURT: You are saying as far as drunkenness, the kind of drinking that makes a person unable to perform on a job, unable to get to work on time, unable to attend every day, that is what I am really concerned about.

Do you have any judgment whether there is more of that among methadone patients than among other people?

THE WITNESS: No, I don't think there is any more.

THE COURT: I take it the people who see patients are interested in detecting if there is any problem drinking?

THE WITNESS: Daily?

THE COURT: It doesn't show up in your urine, as you said, right?

THE WITNESS: That is right.

THE COURT: How do they detect any problem?

THE WITNESS: We are one of the few programs in the country that use the breaholyzer.

THE COURT: What is that?

THE WITNESS: That is an instrument to measure the alcohol content circulating within the blood through a breathing test.

THE COURT: And you call it?

THE WITNESS: A breatholyzer. We are very experienced in observint behavior post-alcohol intake.

THE COURT: On one more point that you gave me a few minutes ago. You said after the first year there was less and less involvement in illicit drugs and I think you said sometimes a cessation.

I got the impression there that absolute cessation of illicit drugs you said was somewhat of a rarity?

THE WITNESS: It is not a rarity after the first year.

THE COURT: Why don't you enlarge on that.

THE WITNESS: Let's exclude alcohol from illicit drugs. It is not illicit, it is licit.

THE COURT: Fine.

THE WITNESS: We are talking about opiate involvement or synthetic opiate involvement, barbiturates, glutethamide, Librium.

THE COURT: Cocaine?

THE WITNESS: Valium and possibly cocaine. That is a substance you could pick up on analysis unless the individual has taken it within the last half hour so you don't get a person that has taken a blow of cocaine and runs into the Center to give a urine analysis. It is so quickly metabolized, it is impossible for us to pick it up.

THE COURT: You mentioned the drugs in the illicit drug category?

THE WITNESS: Yes.

THE COURT: Would you expand on the frequency, tell us what you can about the frequency of that problem, degree of that problem after the first year. The reason I am asking, a number of witnesses have used a year as some kind of point of demarkation.

MR. DUNN: Are we talking about the methadone patients as opposed to 30 per cent? Free patients under ARTC?

THE COURT: I think when you were giving us the trend beginning with the first eight weeks and all, I got the impression you were giving it for everybody.

THE WITNESS: That is why I classified the patients coming on the program. About 2 to 5 per cent of the patients that initiall come on the program come on as drug free patients. They might come out of prison and will come to the program the same day because they don't feel they want to be out where they will be exposed to drug abuse without the help of a program, so this person has no drugs in his system but has a history of drug addiction behavior and he wants to avoid any possibility of becoming a recidivist so he comes into the program.

This kind of individual does not abuse drugs within the first eight weeks of his stay on the program. He might not abuse drugs for the whole first year or he might trip, as we call it, maybe once or twice during that whole first year and without returning to a steady pattern of drug use which would end up where he could be again called an active addict individual.

Then there is another group of patients, the other 25 per cent of the hundred who are drug free who have come on the program initially as methadone patients who were actively addicted at the time of entering into the program and met the criteria for admission and who went from methadone dosages of say 50 milligram, 40 to 50 milligrams down to zero milligams and are then considered drug free.

THE COURT: In what period, a fairly short period?

THE WITNESS: It could be a short period of time. It is relative to the patient, how amenable he is to treatment, how well he embraces it, how attentive he is to himself and in getting a job, et cetera, et cetera.

THE COURT: He is the fellow that comes in in order to be detoxified?

THE WITNESS: Not necessarily. He might join this methadone program to be maintained on methadone as his choice of treatment for himself. In doing so, he might have made up his mind in a much more stronger way. He might be more stronger willed and instead of being maintained for a longer period of time, his maintenance might last for maybe two months then suddenly he'll say I want to be detoxified because I think I can manage without the support of methadone itself and he becomes a member of our detoxication process and goes down to zero and he finishes that off In three months or three and a half months so he becomes drug free after that time and in a lot of instances, he remains drug free.

As a matter of fact, I have certain patients who have detoxified themselves, did not show up for their medication. They might have missed medication one week and that day they said, we didn't get so sick so they don't come back that Monday for their medication but they will continue to come back for counseling or for their medical sessions and they will detoxify themselves abruptly which is almost unheard of but it happens.

THE COURT: This 25 per cent you are mentioning, the people that go through methadone relatively quickly, how do you classify them as to the problem of continuing drug abuse, illicit drug abuse?

THE WITNESS: Post the first year?

THE COURT: Any way you want to describe it.

THE WITNESS: After the cessation, once they are detoxified, I would say maybe 5 per cent of them might abuse substances intermittently but I think what we are looking at here is a little bit different problem. What we are looking at here is a disease entity that is chronic in nature and people can exacerbate any other disease entity except this one.

By the very way you are asking me the question makes me know that we don't recognize this or you may not recognize this as a chronic disease entity where people exacerbate from time to time depending on many factors; some environmental, some psychogenic. A number of factors.

I think in this diseas, we have to look at it like we do all diseases. If I had TB and I had to be isolated and I was cured and happened to come upon some hard luck and exposed again to the weather, et cetera, and my constitution was a little low and I got TB again, I would go right back to treatment and be treated and still be functional and no one would say anything, but in this disease, there is what seems to be a bias, or a preconceived notion that people should not exacerbate, or should not become a recidivist and I think it is incredible that we even think of this disease in this fashion. It is like all other diseases. When conditions are optimal, of course there may not be an exacerbation and you will have continued success with this disease, but when they are not, there could be some occasional and intermittent substance use, whether that substance be opiate-like or a combination of substances that will give an opiate-like feeling, which in some instances is therapeutic.

THE COURT: I think you probably realize it without explanation but we have had had testimony, for instance, from Dr. Dole that someon who is a heroin addict really is not employable. At least he wouldn't have a constitutional right to demand employment from the Transit Authority if he is a heroin addict. I don't know all about heroin addiction but anyway that has been told to me.

If you have someone going on methadone, it is important for me to know, and I don't know what I will do with that finding, but it is important for me to get an idea of the risks of someone returning to heroin and it is not that he is a terrible person for doing it or that he is an outcast or anything like that, but it affects my ability to decide this case.

If, for instance, the man who is on methadone, if 80 per cent of these people on methadone used heroin once a week and let's take that situation, it would be important for me to know it, it would be important for the Transit Authority to know if they were looking at a group of methadone patients to decide whether they could employ them. So, that is the kind of thing we are interested in. We are not really passing, I think the kind of judgment you are concerned about.

THE WITNESS: Could I answer you then?

THE COURT: I just want to make it clear. I am looking at this solely from the standpoint of someone who has to decide whether the Transit Authority has got a constitutional obligation to consider for employment methadone patients or can, within the Constitution, have a blanket exclusion policy saying they won't ever consider a methadone patient, and so we are putting all the parts of that puzzle together. Okay.

THE WITNESS: I would like to answer you first by saying that a patient who is on methadone would have no reason whatsoever, once stabilized, to again shoot heroin. I want that absolutely clear. It is just pharmacologically imposssible for him to realize any feelings from the heroin because of the cross tolerance of methadone and heroin.

That's an answer to one of your questions, that people even -- and we will call that the psychological blockade that occurs -- where an individual, once he is stabilized, what this man or person does is try to overcome the methadone by shooting up enough heroin. He finally finds out that he cannot even purchase that amount of heroin that could overcome the amount of methadone that he already has where he could feel that substance.

So he just automatically stops at one point or another. Generally, that point is from in the first eight weeks and almost, you know, doing -- after that first eight weeks, he realizes that it is just impossible for him to do so, so he doesn't shoot up heroin any more. So that unequivocally is, you know, just a no no.

So, if that's one of the poins you have to make, you can make that on, you know -- on whatever decisions you make, I'm sure that is everybody's testimony, because he's just not going to do it. He might use other substances, like other people use other substances, which makes him more or less a normal human being except for the fact that he has methadone aboard within him at that time. But that doesn't mean that he is -- should be disqualified from a job or working for the Transit Authority. None whatsoever. That's not what I mean.

I tried to be as factual as I could from my medical expertise, you know, when explaining those things to you, but you have surfaced that question and, therefore, I answer it emphatically, that under no circumstances would this individual have need to take an opiate-like substance or a greater propensity to, really.

THE COURT: When people talk about drug abuse, what are they talking about with methadone patients? They are talking about, I guess, taking other things, barbiturates, amphetamines and so forth. Your staff attempts to discover whether they are doing so, right?

THE WITNESS: Yes, sir.

THE COURT: Because you want to help them avoid even that, right?

THE WITNESS: Exactly, sir.

THE COURT: Now --

THE WITNESS: Sir, a lot of that is myth, also, and a lot of that is preconceived notions on the part of laity, that once an addict, always an addict. I want to be very emphatic about that.

You know, I have had very personal experiences with addicts, one from my own family, with whom today even as a physician it is very difficult for family members, though he's rehabilitated through a drug-free kind of modality, to really accept him and embrace him as a non-drug-taking individual, just from mythical kind of misinterpretation and misunderstandings of what has gone on in association with these people. They're indelibly imbedded and stigmatized, secondary to the disease entity that they have gotten themselves involved in, and despite the sophistication of my family and me as, you know, a reknowned drug rehabilitator, they still walk away with those preconceived biases and harbor them, and it becomes truth within their minds.

And I submit to you, your Honor, that this is indeed what that is all about. People who are on methadone or people who become drug free do not necessarily have to abuse drugs, just because that has been said in society.

THE COURT: I think that is clear. The only thing is if we could make you start in describing the best way you could the percentage or instance of use of these other drugs, and you were talking about the 25 per cent who went through methadone and off of it in a relatively short period of time. I think you ended up saying that only about 5 per cent after that would abuse these other substances.

Now, that kind of estimation, in terms of percentages, is helpful to me, and I take it that the big majority of that 25 per cent group would not use the illicit drug substances?

THE WITNESS: Would not at all.

THE COURT: Would not at all. Okay.

Now, I guess the next group would be, in fact the people who come to you drug free, would that be about 5 per cent; right?

THE WITNESS: Yes, sir.

THE COURT: Now, that is your 30 per cent that you mentioned earlier, right?

THE WITNESS: Yes, sir.

THE COURT: Okay.

Now, the 70 per cent who are on methadone for more or less long periods of time, can you give me the same kind of a description, even though it may repeat something you have already said? But let us go through that, all right?

THE WITNESS: That 70 per cent, after the first six months on a program, depending upon -- and I hate to keep prefacing things, but that's what the facts are -- depending upon their readjustment socially, educationally, vocationally, et cetera, you know, and even with the judicial system, because they might have indeed had a bench warrant and so forth, depending upon all of that being cleared up, they do not involve themselves in drug --

THE COURT: After six months?

THE WITNESS: After about six months. Once they're on methadone and are doing fairly well, they have no need to involve themselves. However, those individuals who still find themselves floundering within society, without a job, without a decent place to stay, without any direction whatsoever, being constantly still harassed and with a low esteem of themselves do have a tendency to get involved in some kind of substance abuse intimately before the next six months, which will bring it up to a year.

Then, after a year, they rarely get involved in any opiate-like substance abuse at all, but might get involved a little bit heavier in alcohol, or it might even take a sleeping pill to psychoactively -- to change them psychoactively. And I don't find, very frankly, that to be too abominal. I mean, I find it very acceptable behavior, as a matter of fact, because they're still functional.

It's no different than an individual, as I described before, in the major society who takes a meprobamate two or three times a day.

THE COURT: What is that?

THE WITNESS: A tranquilizer. Or Equinol, or who takes Librium, 5 milligrams four times a day, or who takes Valium --

THE COURT: Librium is what?

THE WITNESS: Librium is also a tranquilizer substance.

THE COURT: And the last one you mentioned?

THE WITNESS: Valium is also one, and they're the two most highly abused drugs in this country, and they're taken by the majority of the society, not just addicts.

THE COURT: Majority of what?

THE WITNESS: The society. Well, I would say this: that middle class people abuse those two drugs more than addicts abuse those drugs. And we accept it quite normally, but yet when we are talking about the person who has an addiction history, we're saying well, gee, that's bad. You see, when it really isn't bad, because that could be his therapeusis, too.

As a matter of fact, your Honor, the wine could be his tranquilizer, that he canot's afford to go to the doctor. Or when he does go to a clinic with Medicaid he's embarrassed because he's got to sit there for an hour, and then if he had a history of drug abuse behavior, even if he needs a tranquilizer, the doctor won't even prescribe it for him.

So he has to resort to heavy doses of alcohol or to illicit uses of other substances just to be able to adjust to this cockamamie society in which we belong.

THE COURT: What you are saying is that this can happen --

THE WITNESS: With anyone.

THE COURT: It happens out in the methadone clinic?

THE WITNESS: No question about it.

THE COURT: All right.

Now, what you have named as the tranquilizers, let me start again. We have used the words amphetamines and barbitrurates in this case a great deal. Now, the tranquilizers you have mentioned, do they fall in either of those categories?

THE WITNESS: No, sir.

THE COURT: What is there about an amphetamine and a barbiturate, is it worse than a tranquilizer?

THE WITNESS: Well, an amphetamine has a different effect than a tranquilizer.

THE COURT: That is the hallucinogenic?

THE WITNESS: No, sir. An amphetamine gives you a high. It's -- I don't want to oversimplify it for you, but I don't know where your head is in terms of pharmacology, either, so if I'm being oversimple, you let me know.

THE COURT: Sure.

THE WITNESS: Amphetamines raise the blood pressure; amphetamines increase the pulse rate; amphetamines are Adrenalin-like drugs or sympathomimetic drugs, meaning they mimic the sympathetic nervous system which gets you ready for feats, you know, of extraordinary energy, for

So it is an up in a common sense of the word. All right.

Whereas, a barbiturate is a depressant substance. It's a central nervous system depressant, and it instead of getting you up, it puts you down. It slows the blood pressure, it slows the pulse rate, it slows the metabolism, and it sometimes upturns or partially upturns the ability to function.

A tranquilizer, which could be a phenothiazine-type drug, like Librium, and of course Valium, are, are those substances which act in the same kind of way as a barbiturate but are not of the same class of substance.

THE COURT: When you say "not of the same class"

THE WITNESS: Well, a barbiturate is of a special chemical formula in which phenothiazines are not.

THE COURT: I mean, whatever we take as the criteria for saying that drug is more potent or less potent, more dangerous or less dangerous, is the barbiturate worse than a regular tranquilizer?

THE WITNESS: Some barbiturates are more potent than tranqilizers. However, if you increase the amount of the tranquilizers, they come in different, say, denominations like dollar bills. It's the same size as a dollar bill but it has a greater concentration of the substance that does the work with in that capsule.

So if it's a 5 milligram Librium or 10 milligram Librium, a 10 milligram Librium might be a great deal more stronger than one of our short-acting, low-concentrated barbiturates.

THE COURT: Okay.

THE WITNESS: Do you follow that I'm saying?

So that it depends upon which one of these substances -- I hope I am not --

THE COURT: That is fine.

THE WITNESS: By the way, I am not exasperated here, either, when you ask me these questions. I just did not know that we were going to have to -- I didn't know that I have to -- whether I should have brought my pharmacology book or not. I want it as accurate as possible, you know, and memory doesn't serve me any better than it serves you.

My basic pharmacological training in medical school, which is 15 years ago, and your basic law training, I don't know when it was, but I'm sure your memory is not different than mine. You have to refer too. I'm not as equipped with you, so I can't a hundred per cent --

THE COURT: That is fine.

Now, back on the 70 per cent, you were describing the extent and reasons for illicit drug use for the methodone patients. Now, I think what you told me -- let me see if I am summarizing it right -- after six months if you have a man who has adjusted fairly well, that is, he has got the normal things going for him, he has got a good family, and he has got a job, and the other factors that are more or less favorable than those factors, the incidents of him taking cocaine or barbiturates or amphetamines, the kind of thing we call drug abuse, that would be very small, I take it?

THE WITNESS: It would, sir.

THE COURT: If I'm not saying it accurately, you correct me.

THE WITNESS: Yes, sir. I would exclude cocaine from that category.

THE COURT: Because cocaine is so rare?

THE WITNESS: Not really.

THE COURT: Why would you exclude it?

THE WITNESS: I do not think we know exactly how much cocaine abuse is going on in these United States and by which segment of the population. As a matter of fact, it's such an expensive drug that it's a very -- on the street, when you get it illicitly, and that very few people can afford to abuse cocaine -- you know, it's most heavily used by our rich. It has been, you know, postulated as such. But never really been proved to be absolutely the gospel that it's used primarily by the rich.

But we do get some cocaine abuse or use among this group of patients, but it's difficult to prove, so I don't think you want to talk about that one.

THE COURT: Right.

THE WITNESS: I think you want to talk with amphetamines or barbiturates or the phenothiazine.

THE COURT: Or alcohol problem drinking?

THE WITNESS: Yes, sir.

THE COURT: Now, so I take it that if a fellow has gotten into the methadone program and lasted for six months and he has these objective things worked out fairly well, the incidents of drug abuse or alcohol abuse that we have talked about, you and I, that is relatively small, right?

THE WITNESS: Yes, sir.

THE COURT: On the other hand, if you have got the things not working out well, the fellow has got problems and he may resort to the drugs or alcohol, right?

THE WITNESS: No question. As a matter of fact --

THE COURT: In your program, just thinking over the patients that, you know, are in your program, about what per cent, roughly, are able to make this adjustment and have these favorable factors after the six-month period; is this a tiny number or is it a substantial number or what?

THE WITNESS: After the six-month period?

THE COURT: Yes.

THE WITNESS: Okay. I'd say around 15 per cent of the total population of the 70 per cent who would be on methadone. Now, in my total patient population I have about 35 per cent of that total patient population gainfully employed and really enjoying a regular home life and functional and not abusing these substances, which is miraculous, your Honor, with the kind of profile that they came into the program with in the first place.

I mean, you know, when you have 35 per cent of that 1,700-some patients that I have employed, when the unemployment rate, you know, just for normal human beings is about 8 per cent and for blacks it's about 20 per cent and for a guy who had a profile of an ex-addict, ex-criminal tenth grade education, got to be 60 to 70 per cent of unemployment in his group of people. And we have 35 working and doing exceptionally well, and being engaged by a yardstick or measured by a yardstick which is far more rigid than the normal guy is measured by.

THE COURT: What are some of the jobs that they are holding down and doing well at?

THE WITNESS: Oh, sort of a cross the board.

THE COURT: Before we get into that, though, I do not want to forget this.

THE WITNESS: Yes, sir.

THE COURT: There are two things. You gave me after six months. Now, let's say after a year, you have more people who have a better adjustment by then?

THE WITNESS: Oh, yes, sir. Considerably more.

THE COURT: So the 15 per cent would become what?

THE WITNESS: 60 or 70 per cent.

THE COURT: That are reasonably well adjusted?

THE WITNESS: Exactly.

THE COURT: All right.

THE WITNESS: And if they have some crisis situation, would indeed imbibe a bit more, you know, as normal citizenry do who have no historical background of drug abuse patterns.

THE COURT: But after a year, you have got a lot more people that are reasonably well adjusted?

THE WITNESS: Unquestionably.

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THE COURT: Okay.

Now, the 35 per cent that are employed, would you have an idea of about what proportion of that are drug-free people or what per cent in propostion are still on methadone?

THE WITNESS: Oh, I would say of the 35 per cent, I would say about 70 or 80 per cent of those are on methadone.

THE COURT: All right.

What kinds of jobs are they doing, the whole 35 per cent? Let's just take that.

THE WITNESS: I would like to defer on that question, your Honor, because I would think the manner in which you're going after this thing at this point, that you need to know accurately and as to the point as possible, and I would be willing to check with my vocational and job development director and submit to you the types of jobs, because as executive director, you know, this is a big program. I've got 500 employees, you know, and I wouldn't want to off the top of my head say I had ten people who worked at the Park Department, and 20 who worked for Wildcat, and five who were chauffeurs, you know. I wouldn't know that kind of information just like that.

And I'm sorry, I'm not prepared to answer that. Had I know, you better believe I would have been prepared to give you that kind of response and I would much rather do it the other way if you will permit me to do so.

THE COURT: I would like to have it. I do not know, we've had a fairly long group of trial days and maybe I do not know that we will defer for that, but let us take that up later.

THE WITNESS: Yes, sir.

THE COURT: If you could answer this:

The people that are employed, obviously if they are under methadone, they are having urine tests regularly, right?

THE WITNESS: Yes, sir.

THE COURT: If they are drug free, are they still having tests?

THE WITNESS: Yes, sir.

THE COURT: Okay.

THE WITNESS: Our drug-free patients and almost in any drug-free situation, if they patient is asymptomatic, that is to say, if he does not have a medical problem and if he doesn't have any social problem that's bothering him, that he wants to talk to his counsel about, he might not necessarily come into the program for a week or for ten days.

It's just like anybody else who, if you have high blood pressure and your doctor says:

Okay, come back to me in two weeks, that's when you're going to come back and you might not even come back in two weeks if you're feeling all right.

That's just the nature of our behavior in response to therepeusis, no matter whether it is chemotherapeusis of whatever kind it is in any disease.

So when you ask me about my drug-free patients, whether each week they give me a urine, I would say they do not give me a urine each week, but each time they come into the clinic they do.

Now, they're required indeed to give a urine onceor twice a week by law, by Federal statue, but it does not often happen and you can't go out and get them. They say, "Well, damn it, why should I come down to the Center? I'm doing fine. There's no need. You know, I'm here, you know, when I need to be here."

And I think you can understand that. I think what needs to be done is that we have to educate the society around the behavior of people who are being rehabilitated in drug abuse, and that their antics and behavior patterns are really no -- basically no different than ours would be being treated for a disease entity that is quite similar.

THE COURT: Okay. Now, this is a question that we have explored with some other witnesses. If you were at the Transit Authority, and let's suppose you were attempting to decide what methadone patients to hire for what jobs, suppose you were willing to do that or directed to do that by a Court or some other reason you are doing it.

Now, the question I have wondered is, how difficult it is to determine the ability of that particular man to perform the job. I will assume that among the methadone patients in this city there are in fact some that are capable of performing many jobs at the Transit Authority-- I will just assume that, that they exist -- that they would do well. But let us explore the question of how does the Transit Authority determine in advance which are going to work out okay or have a reasonable prospect of working out okay and which may be in the category that are still deep enough into a drug problem that they should not hire him. I mean, that would be a question you would consider, wouldn't you?

THE WITNESS: Yes, sir.

THE COURT: We do not have or we are not prophets, and so how does the Transit Authority go about that? Would it be a judgment that their ordinary personnel could make? Do they hage to hire an expert consultant because the decision is an unusually difficult one? Or what? How would you assess that?

THE WITNESS: That probably singularly is the most important question that you have asked me today, and it will take me a moment to reflect.

First, I do not think that I would use any different criterial for this individual as I would another one. That is, qualifying criteria, education, physical examination, mental acuity, right down the line.

If the individual indeed has had a history of drug abuse behavior and was on a methadone program, that's going to show up in his urine analysis at the time of physical examination when he's getting ready to be employed.

The physician, and I mean any physician in this day and time with the high incidents of drug use and abuse within our society, that regularly examines any patient that the Transit Authority should be equipped -- and if he's not, he ought to be fired, your Honor. Okay -- to look at that disease entity as well as one of a common cold.

And doing so, he should be able to evaluate that individual as a prospective employer as well as anybody else.

If the Transit Authority hires people who have had a history of tuberculosis or who have had a history of any stigmatizing kind of disease, they run that individual through for a chest x-ray every six months, or in some cases every three months could hire an individual who completely passes, who might have sarcoidosis, which is a very common disease among certain people, and Transit Authority has a high incidents of blacks and browns that work for them.

So that these diseases that I'm talking about are pretty common disease among these people. They have their physician, and things set up to check them. They, too, could have their physician, you know learned to check these people out by a periodic test.

If the man got a job there, one of the prerequisites for him working should be that he should be able to give a urine Q two weeks, or intermittently check on him every few weeks, period. You said how would I do that?

THE COURT: Let us suppose you have a man, no question he is a patient in a methadone clinic and he wants a job. We won't worry about which job right now. You find out -- perfectly honest with you -- you find out he was a heroin addict for ten years and he has been a patient at a methadone clinic for a year.

Now, there are some things you would want to consider about that circumstance, right?

THE WITNESS: Sir, as a matter of fact, your Honor.

And each problem has its unique consequences, right?

THE WITNESS: Yes.

THE COURT: Tuberculosos has its consequences?

THE WITNESS: Sure.

THE COURT: Heart problem has its consequences?

THE WITNESS: And so on.

THE COURT: I am worried about the consequences that have to be considered of somebody who has been a heroin addict and is now on methadone. Now, what are the problems you would have to consider if you sat there? You are considering the public's safety, you are considering the man, you are considering all the way around. What would you be concerned about? What should you be concerned about?

THE WITNESS: First, I would be concerned about illicit drug abuse.

Secondly, I would be concerned about whether he was even taking his methadone on a daily basis. That would be the problem of greatest concern.

Thirdly, I think that I would set up some kind of liaison -- as a matter of fact, when a guy from a methodone program would go to the Transit Authority to work, he's going to have to admit that in the beginning, from the outset. They already know he's a methadone patient.

And one of the requirements should be that this individual should cooperate or sign some release so that the medical information from the methadone program would come to the Transit Authority examining physician.

THE COURT: Right.

THE WITNESS: And periodically, knowing how hard jobs are to get, knowing how hard it is to get a methadone patient hired, that the methadone program should be responsible for reporting any behavior, any behavior that is away from the norm to the physician at the Transit Authority, or to the health authorities there. It doesn't have to be a physician.

And a continuous liaison between those two individuals until such time as they deem it unnecessary to continue that kind of relationship.

THE COURT: You would want to make some assessment as to the degree of rehabilitation, as you put it earlier?

THE WITNESS: No question about it.

THE COURT: Okay. And you would also want to know something about the reliability of the clinic he was coming from, wouldn't you?

THE WITNESS: No question about it.

THE COURT: Now, the question that has really concerned me, Doctor, is how is the Transit Authority going to make judgments about the reliability of the clinic, the possibility of drug abuse, the extent of his rehabilitation and all those factors? And they probably are all rolled up so that they intermingle. How is the Transit Authority going to make that judgment?

THE COURT: Well, I don't think it's a very difficult one, and I know that you know that people -- I'm making it a bit simplistic when I say that to you. First of all, if the other authorities did their jobs, that is, each clinic has to be licensed by the State Department of Health, by the New York State Bureau of Narcotics & Dangerous Drugs, by the Drug Enforcement Administration, also by the New York City Department of Health -- that there are four specific governmental agencies, both State, Federal and City, that are responsible for the licensure, and once you are licensed and you have to meet certain criteria before You are licensed, there are constant inspections.

Methadone programs, your Honor, are under the greatest scrutiny. Microscopic scrutiny, as a matter of fact, almost every three months. That once that decision is made by those institutions whose responsibility it is to check, I think the Transit Authority could have a list of those programs which are indeed recognized as legitimate and functional. That's one way.

The other way that the Transit Authority, they have physicians. Physic ians are, in a sense -- community with one another. It's a fraternity. Medicine is a fraternity like law is a fraternity. And I see no reason why that doctor, John Doe at the Transit Authority, couldn't call Dr. John Doe at program X and talk about patient X at any given time.

And, you know, I know how much my colleagues talk about me and I talk about them when something bad or good happens within the profession; that it's very easy for them to find out which program is bad and which program is good. I mean, just from an internal kind of -- an inner sanctum kind of way.

You know bad lawyers and you know good lawyers; you know bad judges and you know good judges, whether they are on the Federal bench or whatever bench. The same thing with doctors, make no mistake about it.

And I see that not as an encumbrance, I see that as something that should have been worked out a number of years ago, for that matter. I mean, it's just because there is no initiative on the part of those individuals who are working with in this field, and it's a perpetuation of the attitude of physicians in relationship to the kind of patient that we're talking about secondary to the Harrison Act and all the other kinds of things that you know historically have happened in this field.

THE COURT: Okay.

Now, in evaluating the program, let me get an idea. In one of your clinics, about how many patients would come in a day? What I am leading up to, we have had testimony here that the rehabilitation and counseling services that the methadone programs claim to give really are not given.

THE WITNESS: That's absolutely correct.

THE COURT: That a lot of times all they really do, despite claims otherwise, is just to give out the drug. They have so many people coming in each day, their staffs are so small and so forth.

Now, I would like to get a better idea of that. I am just telling you the issue.

Now, can you comment on that?

THE WITNESS: Surely I can. The Federal Government states that there should be a patient counselor radio -- I think it's 60; it was just raised approximately 60 to 1. In my program I will not allow them to have more than 40 to 1.

I thought that the law was excellent when it stated that there should be a 30 to 1 ratio. That means that that one counselor could be responsible for 30 patients, and in a given week could see them all if he saw them all if he saw them, say, six a day. In a five-day week, he would be able to contact six a day if no more than by telephone. Okay?

When we talk about counseling services being non-existent, we have also got to talk about programs, and the proliferation of programs in the City of New York has been such that they cannot be kept up with by the State Departments who are responsible and the City departments who are responsible. So the monitoring of their acts has been lax in a sense.

So therefore, they could get away with less counseling and patients than when they're within a lax system. Take advantage of that system and don't come as mcuh.

Now, if you've got 250 patients like each one of my clinics do have, I would say in a given day that maybe one-third of those patients are not coming into that clinic even though my clinic is fairly rigidly run.

Now, if my clinic was one that was less than a free one, lets's say one where I was a profiteer, as many physicians are who are in this field, and who might indeed have been working at the Transit Authority, my patients may not get any counseling and would be like a watering hole, you know. If it's a profiteering kind of setup. But they're going to know the profiteering setup because then the private methadone programs, and the private methadone programs are the ones who are most likely not to have all the services there, whereas a Federal and City funding kind of program has got to have the services there, lest it cannot stay in existence.

THE COURT: Let us start with the services at the ARTC. You have about 230 patients in each clinic, right?

THE WITNESS: Yes, sir.

THE COURT: And you say about one-third do not come in each day, so about how many would come in each day, just roughly?

THE WITNESS: If let's say it's a Monday, on

Monday we'll get, oh, say, 200 out of the 250; but say on Wednesday again, you know, once -- let's take a given week. Tuesday would vary anywhere from 225 to 180, something like that.

am THE COURT: Let me go back. On a Monday, how many people would be coming in?

THE WITNESS: Generally our greatest number coming in. Say 210 out of 250. It depends on the spree decor of the clinic. It depends upon a lot of things. He will come in for his methadone but may not come in for counseling on that given day. He may come in, drink his methadone and head right out, but generally over the weekend, they miss a day. Invariably most patients will mis one or two days on the weekend. You have to be an exemplary patient In my program to take your medication home for the weekend so they all get in on Monday.

Do you follow me? That is the reason we get a great number coming in on Monday.

On Tuesday, we might get 186 people, something like that. Wednesday it will go up to say 200 and it will vary throughout the week and on Friday again, we will get a great majority. Sometimes a full complement of patients will come in, sometimes 250 on a Friday because it is before the weekend, they want their medication and then if they take that dose on Friday, it will at least last them until Friday night, Saturday morning and they will come back on Sunday or Monday.

So, we are talking about a pretty good program like in ARTC that is rigiduly run.

A great number of the patient population attend sessions on a daily basis.

THE COURT: At each clinic, how many counselors do you have?

THE WITNESS: For the 250, we always go about 40 to 1. We will have six counselors.

At ARTC, it is a very special kind of thing. To work there, if you are a janitor, you have to take an examination that I have devised that denotes to me kind of generically that you have some knowledge and some appreciation for the problem of drug addiction rehabilitation.

It is most important to me that any time a patient sees anybody working in the clinic, that that employee engages that patient in some kind of process, if it is no more than say "How are you doing today?" or "Hey, don't put that cigarette on the floor, put it in the ash tray."

Everybody in that clinic, no matter whether he is clinically employed or administratively employed should engage the patient. So, it is not just the counselor's job. There could be a personality conflict between the patient and the counselor and he may be counseled every day because he is assigned to that person but not really get to this guy whereas the janitor could get to him and start to rap with him on the side and you would be surprised at the change in behavior of this individual so everybody in my clinic has to engage patients so when you are talking about six counselors, if I got 30 employees in the clinic, all 30 are counselors and six might be specifically assigned to that duty and are specifically qualified for it but everybody is a counselor and that is why we have an IDT because the IDT sometimes would have the janitor come in and sit on that IDT that makes some determination about this person's progress and behavior.

THE COURT: You said you have six counselors. How many doctors at each clinic?

THE WITNESS: One physician per 300 patients. We have one and a half physicians per 250 patients, so we have more.

THE COURT: The equivalent of about one and a half doctors for each clinic?

THE WITNESS: Yes, sir.

THE COURT: The people involved in those other phases --

THE WITNESS: That is full time, your Honor.

THE COURT: Doctors?

THE WITNESS: Yes.

THE COURT: How about people involved in some of these other things, social services, education?

THE WITNESS: Social services is the counseling.

THE COURT: What other employees would you have at the clinic?

THE WITNESS: We would have six counselors and one supervisor. A supervisor counselor. They would be responsible for Medicaid registration, any social involvement with the welfare system, subsistance, housing. where they live, family intervention. That is what these counselors would be involved in.

Then we move to each clinic and we have a job developer and sometimes two. We have two teacher types, accredited, teachers who are responsible for teaching classes to people for GED, high school equivalency diploma.

THE COURT: How many people in the education field?

THE WITNESS: Two per clinic.

We have one legal advocate who is responsible for doing nothing but seeing to it that they get to court and are properly represented, et cetera. We will have three nurses, one who is responsible for the overall administration of medical records and so forth and the other two who are responsible primarily for the dispensing of the medication in the clinic.

We will have one pharmacist aid who is responsible for making sure the labeling is correct, et cetera, et cetera. We have a urinalysis technician, two of those, a male and a female, who under their strict surveillance watch the testing of specimens. Of course, we have a facility director and administrative aid to him, one and one-half physicians, a secretary to each one of these departments and cleaning and maintenance personnel. Roughly, that is the makeup. It comes to around 30 people, between 25 and 30 people working in a given facility.

THE COURT: How do you set it up so that a person gets counseling? Is it up to him whether he wants to see the counselor or do most people skip it?

THE WITNESS: Sure they try to skip it. We generally capture them at the very place they want to go. We know they have to come in there for their methadone because if they don't, they get withdrawal symptoms.

They are addicted to methadone. That is the treatment.

So, at the dispensing station, we have our clinic sort of arranged architecturally so that the counselors sit where they can see that area and they can capture the individual there. The most difficult thing in drug addiction programs as in any other program is engagement, engagement of the patient and we make it possible, geographically for it to take place. We make it almost impossible for him to get out of the Center before he could engage someone who is a participant in the rehabilitation process. So, the guy who is in the recreation room over here says "Hey man, did you see your counselor?" If he comes through there. If he comes through the other door, the receptionist says "Make sure you see your counselor" or he picks up the tab at the reception desk and tells him he has to see his counselor or he has to go to medical for X kind of examination.

It is run like that so engagement has to take place.

THE COURT: Do you have a requirement that a man has to see a counselor so many times a week?

THE WITNESS: Not necessarily.

In the first stages, in the first eight or ten weeks of the program, generally so, he is seen every day, but after that occurs, he might see his counsel once a week. That might be all that is necessary.

By the way, we have also a mental health section and there is a mental health person, a psychologist type in each one of these facilities and a therapist, group therapist type.

THE COURT: We have had testimony, and some of this had to do with observations some years ago and some more currently that I think we had testimony up at the Bronx, the State treatment program there with a lot of congregating by the patients outside the facility and they congregate and they drink rather heavily. Their behavior has been a problem to the hospital so they have had to bar these people from the hospital, actually put them out. We have had testimony that the same thing occurs at the Veterans Administration Methadone Clinic. Congregate for drinking, congregating for passing pills. That is something I don't quite picture and I haven't been there.

THE WITNESS: Let me picture it for you. That indeed happens. I think at my own clinic you might have heard and I will testify to the fact that indeed that does occur. That is one of the most difficult problems.

THE COURT: What occurs?

THE WITNESS: There is congregating outside of clinics, no matter where they are located. You could do a great deal to cut down considerably on that kind of congregation. It is no different than when people go to church on Sunday and they stand around the church for an hour or they go to something else during the week and they stand around and talk to each other. Birds of a feather flock together and there is a commonality and communality just there. They don't have any place else to go in most of these neighborhoods. At least in the ones I serve. There is no recreational facility so what they do is stand on the street which is, by the way, a common practice.

Have you ever driven through Harlem or Bed-Stuy or El Bario or the South Bronx, black and brown people, they can't stand those apartments and they congregate and they rap.

As a little boy in Harlem growing up I played and danced on the street corner and hung around the street corner and I congregated there sometimes for good things and sometimes to whistle at the girls. That is what is happening now. Behavior doesn't necessarily change because a guy becomes an adult. Who the hell are we to chase them away from the front of the building anyway? That is public property. The only reason we talk about the congregation is because the other people who do not understand the behavior problems of a dictum object to their being there because they are afraid they are going to get ripped off and so on which is absolutely not the case in my area, but it creates an anxiety and I think it is an unwarranted anxiety.

THE COURT: The thing that concerned me was not the standing around and talking, but if this was the kind of facility for passing drugs among each other or encouraging each other to drink or take drugs, that was the feature that I wondered about. How could we stop that?

THE WITNESS: We have tried to stop that. I think it is impossible to stop because they go right on the next corner and congregate in the front of the whiskey store and pass the wine bottle back and forth. Whether they be from my program or just idle people within that neighborhood that do this.

You ought to go on a tour like that and you would see that it is not just drug programs. This is commonplace in ghetto areas where people do this and I wish I could destroy it. Hell, why do drug programs have to be responsible to bring about social order within the whole society? Who is responsible for it in front of the whiskey stores, who is responsible for it in front of abandoned buildings, in front of playgrounds?

THE COURT: We were thinking about employment for the Transit Authority or Con Ed or whoever. You have testified that there is a fairly high percentage of people after the first year, say, or even after six months who have a good rehabilitation, a pretty good chance of being completely drug free.

I take it they wouldn't be the kind that would be the type that would stop and pass wine or pass pills.

To differentiate, are there sectors of your population that are pretty clearly differentiated?

THE WITNESS: Yes. There is an elitism. That elitism, it pervades the treatment programs. There are some people who would be characterized as a greasy junky. There is another type who has never been involved in anything criminal, for example, and he just doesn't associate with the other people, unless, by the way, it was when they were doing a little drug taking behavior, where, by the way, there is no prejudice or anything else at that time.

I have a problem of discrimination and separation of the races after I get them rehabilitated, but maybe a black and white guy or girl, whatever, would come to the program hand in hand. When they joined the program, they were sharing the same needle or same bottle but once they get rehabilitated, you see a separation of the two.

It has been suggested that one of the ways of solving the race problem is the City was to have everybody get addicted. Then you have a breakaway of the races once they become rehabilitated.

Once again, I point out the elitism in some of the programs. There are people who have never drunk wine, who drink scotch and go to the bars to drink it.

But the kind of individual who congregates outside of the program centers, he is not the kind of individual who is likely be successful on the program, not the type that would be acceptable to the Transit Authority.

THE COURT: And you could determine which is which?

THE WITNESS: No question about it.

THE COURT: I have concluded my questioning.

THE COURT: You could finish up, Mr. Dunn.

BY MR. DUNN (Continuing):

Q Doctor, you said you could differentiate between the patient that congregates outside the program center on the street and the patient that does not. How do you go about distinguishing or identifying the two types of patients?

THE COURT: The successful and the unsuccessful.

A The guy who congregates outside of the program, and I mean frequently, is a guy who is not involved either with family or a job or anything that is meaningful. He is still in the same category as he was when he was using heroin exclusively before he became rehabilitated and he doesn't change that pattern. It is like kids in a school. You know the bad ones and you know the good ones. You know who hangs out and cuts classes and you know who is in the lunchroom sitting at the table like they are supposed to be and not in the bathroom vandalizing it at lunch hour.

It is instinctive, maybe, I don't know what it is that allows me to do it and everybody is able to do it. You know your bad kid and you know your good kid.

Q You were testifying as to how the Transit Authority or any other employer could go about making an appraisal of an individual who was a heroin addict and now maintained on methadone.

Is it your opinion the employer of necessity would be compelled to rely to a large extent on the representations made to the employer by the program?

A I don't think so. I think there should be two sets of input there. I think a person who is actively being treated, is like your diabetic who is constantly receiving insulin. You want to check him from time to time to see if that insulin is correct.

Your doctor, like any other doctor, is trying to help the individual, to see that his health status is normal so he could function normally. I don't think it should be just the programs' responsibility.

Q Isn't part of that determination a history of a patient, both a history as narrated by the patient and affirmed or denied by the program that is treating the patient?

A I don't quite understand you.

Q A prospective employee presents himself as a candidate for employment and states "I have been a heroin addict but for the past year and a half I have been successfully participating in one of the ARTC programs."

Would it not be a rather important consideration on the part of the prospective employer to receive statements from the ARTC program involved and to rely on these representations as being true?

A There is no question about it.

Q And having some basis, not only being truthful but being statements that have a basis on which the employer can rely; that is, that the patient was observed, that adequate records were maintained, proper counseling such as ARTC conducts, was given.

A There is no question about that. There should probably be a transfer of his medical records over his signature with his permission.

Q Let me go a step further.

Are there programs presently operating in the City of New York that you would consider to be inadequately staffed?

A Methadone maintenance program?

Q Yes.

A I would imagine there are some, Mr. Dunn, I do not know. I could speak for ARTC. We are not inadequately staffed.

Q I am not suggesting that ARTC is, but using ARTC as an exemplar, how would you rate the private methadone programs, the ones you referred to earlier as being run by profiteers?

A Some of them may indeed be inadequately staffed. I have heard and I have read this and I don't know how much you could believe the media. I have not visited any of these programs but to my knowledge from what I have read and seen, some of them could be said to be inadequately staffed, compared to a program that was underwritten by the Federal and City funds where we have quite a bit of money and quite a bit of job lines and quite a few things that we have to subscribe to.

Q Can you as an expert and well acquainted in the field give me the name of a privately operated program on which you think the Transit Authority would be justified in relying on representations and a privately operated program in which you feel the Transit Authority or any other large employer could not safely rely with respect to the representations made?

MR. BALBER: Objection. There has been no foundation laid.

A I could not.

THE COURT: That is the answer.

Q Is there anyone to your knowledge that could provide that information, Doctor?

THE COURT: That is up to you, Mr. Dunn, to find out the witnesses. Let's not worry this man with that.

Q What information, Doctor, would you provide to an employer provided the patient sent requests that all information available be provided to the employer; that is a methadone maintenance treatment program patient?

A I think a medical history is of the utmost importance. I think if the man has had a drug abuse or addict history, then unquestionably some social service history should accompany the medical portfolio.

THE COURT: You mean about his family life?

THE WITNESS: With adjustments, et cetera, because this is a disease that has social implications. I think to treat it in a tubular way, just medically, is not the proper way. My program is 70 per cent-30 per cent heavy on the social side and on the medical side.

I would think those two documents and a good summary and possibly even consideration per the telephone would suffice the employer in making a determination of qualifications and ongoing employment of this individual and I think during the first period of time, it probably should be conditional employment and these reports being constantly made, three months, whatever is decided upon, then employment becomes permanent and as long as he continued in that program, there would be an exchange of information which should suffice for the Transit Authority and, indeed, for the person because if he wants to work there, and it is all out in the open anyway, there shouldn't be any problem.

Q Would you have any reluctance if a patient consented and requested that you do so, to make all of the patient's records available for the inspection of the medical director of the authority?

A Over the patient's signature, indeed, I would do so.

Q I am presupposing the consent and the request of the patient that you do this.

A We do have to follow a confidentiality ruling that is set down by the Federal Government and we have to be very careful about that. To a certain extent, exchange of medical information to a physician does not necessarily fall with in that category. My program would read over the request that if it was not in violation of the confidentiality rules, we would not object at all to exchanging the information and particularly if the consent was given by the patient which I feel would exonerate the program from any liability.

Q What information would you give if a patient did not give his consent?

A I wouldn't give you any.

THE COURT: If he wouldn't give consent, you wouldn't even have to think about hiring him. It isn't a thing you would have to worry about.

I would suggest if you could finish this man in five minutes, I would suggest you call your one o'clock appointment and say you will be 15 minutes late so we don't have to have this man running back at 3 o'clock.

Q I have a question about something we had discussed after Dr. Dole testified. Dr. Dole testified in his opinion a person who had been addicted to heroin for a period of two or more years who entered one of the methadone maintenance treatment programs -- let me rephrase it.

Considering persons who had been addicted to heroin for a period of two or more years who have entered methadone maintenance programs, at the end of six months, and the specific question Dr. Dole is asked, would any of these persons be employable as a motorman with the New York City Transit Authority and Dr. Dole's answer was "Yes, the majority."

MR. BALBER: I will object to that. I don't think that is an accurate reflection of the record.

THE COURT: He had a fairly complicated answer. At first he said yes, the majority. Then he said frankly he wouldn't employ any of them as a motorman because of the pressure of public opinion and so forth, so that is his whole answer.

MR. DUNN: He said considering the number of accidents, he wouldn't want it to reflect on the program.

Q Do you agree with Dr. Dole or disagree with

Dr. Dole?

A I would disagree that the majority of people on a methadone maintenance program who were addicted to heroin for two years prior to that entering into the program could be employed as a motorman.

Now a motorman I would assume would be the man who operates the controls of the train in the front car and so forth.

I just feel that we would need a longer period of time to evaluate individuals for that particular job.

THE COURT: A longer period than what?

THE WITNESS: Longer than six months.

THE COURT: Why would you need a longer period?

THE WITNESS: With a history of addiction of two years, it takes at least eight to ten weeks of adjustment for stabilization. That is two months, two and a half months. The next couple of months is relearning how to function within society. Getting his remediation in terms of education, vocational habits, how to allocate his priorities accurately to deal with a life that he hasn't dealt with before in a very orderly fashion. It takes a bit longer than that.

Dr. Dole's patient group is entirely different than mine so when we begin to talk about patients, Dr.

Dole's patient group is probably 60 per cent white --

Q Dr. Dole was referring to the patient population.

THE COURT: You say it takes a couple of months to stabilize, another couple of months to perform that rehabilitation, more or less, what you stated. There is something I think we can explore for a minute before you leave.

Would you in evaluating the question of employability, would you distinguish between these very high risk jobs like running a subway train filled with hundreds of people and other lesser jobs, cleaning and so forth. How would you take that into account in employing methadone patients?

THE WITNESS: Most assuredly so.

THE COURT: How would you do it?

THE WITNESS: How would I do it?

THE COURT: Yes.

THE WITNESS: Well, I would deal more stringently with those jobs than they are now. We have enough accidents and happenings with people who are supposedly healthy who have a stroke and heart attack and so on. I would build in some kind of health criteria that is very stringent and that might exclude, might well indeed exclude, I don't know, it is a difficult one to answer. It might exclude the methadone maintained patient. I would have to do some research on that a bit for a highly technical skilled job.

THE COURT: Would you exclude him entirely?

THE WITNESS: That could be a possibility. I don't know how highly technically skilled this job is. I don't feel that a methodone patient has any loss of mental capacity at all. He might have lost some of his coordination, like a lot of people with different diseases have over a period of time and I think he has to be evaluated very carefully and I know I didn't answer your question.

THE COURT: You did.

You would take care?

THE WITNESS: Great care.

THE COURT: On a job like motorman?

THE WITNESS: That is right.

THE COURT: Do you have anything else?

MR. DUNN: No.

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CARL A. BEAZER, et al,
Plaintiffs,
vs.
NEW YORK CITY TRANSIT AUTHORITY,
Defendant.

72 Civ. 5307

New York, February 3, 1975.

Trial resumed.

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* * *

BENNIE J. PRIMM, having been previously sworn, was recalled and further testified as follows:

CROSS EXAMINATION

BY MR. BALBER:

Q Dr. Primm, during your previous testimony in this case you responded to a question by the Court regarding just how an employer like the Transit Authority reliably screen for employment persons participating in methadone programs.

Just to refresh your recollection, I will read briefly from the transcript what you said in reply to the question--

MR. DUNN: What page?

MR. BALBER: Starting on page 522, the transcript of January 27th:

"THE COURT: I am worried about the consequences that have to be considered if somebody who has been a heroin addict and now on methadone. Now, what are the problems you would have to consider if you sat there, you are considering the public safety, you are considering the man, you are considering all the way around. What would you be concerned about? What should you be concerned about?"

Then you answered:

"DR. PRIMM: First, I'd be concerned about illicit drug abuse. Secondly, I'd be concerned about whether he is even taking his methadone on a daily basis. That would be the problem of greatest concern. Thirdly, I think that I would set up some kind of liaison, as a matter of fact, when a guy from a methadone program would go to the Transit Authority to work he is going to have to admit that in the beginning from the outset they already know he is a methadone patient, and one of the requirements should be that this individual should cooperate or sign some release so that the medical information from the methadone program would come to the Transit Authority examining physician."

Q Dr. Primm, your answer assumed the reliability of the particular treatment program in question, did it not?

A Well, I don't think that makes much of a difference about the program in question.

Q Can persons be screened for employment if a program is what might be called unreliable?

A Unquestionably they can.

Q How would that be accomplished?

A I think there are a great deal of resources that are available to an employer as large as the Transit Authority of the City of New York. Their physician, examining physician, who is in their health department should have sufficient enough knowledge to evalute accurately not only the data that is submitted, but even if it were erroneous, he has the patient right there and he can evaluate from the patient himself or herself. And I think that the program in question, it really doesn't matter that much. I don't think the employer should depend that much on the program in question. I think that that is a matter of protocol, indeed so, that the medical and social history should be transferred under the signature or over the signature of whoever the tentative employee is.

Q Dr. Primm, the problem we are wrestling with here is, just how does that work out practically speaking? A man comes down and applies for a job and he has a reference from his program and the Transit Authority has reason to believe that that program is unreliable.

What practical procedures are you suggesting be followed to evaluate that man?

A I think the Transit Authority should have an examining physician who has had adequate knowledge to be able to evaluate adequately and accurately that patient's capabilities of being employed, and indeed, to my knowledge they already have such people who work there.

Q You are talking about outside consultants; is that correct?

A Well, outside consultants and their own physician. We have in the population almost anyone who applies for a job now such a great number of them who have been previously addicted to drugs that any physician who is examining industrially should have some knowledge about the history of addictive behavior phenomenon and could do an adequate, accurate evaluation of this individual's employment or employability.

Q How would he do it if the treatment record weren't entirely accurate?

A They wouldn't necessarily have to be. He'd take his own history.

Q By interviewing the person?

A No question about it. He could elicit his own history from the individual; he could examine him very adequately; he could look to see if there were any fresh track marks or the old ones; where they are located would give him an indication of how long the duration of use of drugs was, whether he was still actively using drugs. There are very--

Q Would he employ a psychiatric interview?

A Not necessarily. If during his examination of the individual something surfaced that might indicate to him that there should be some psychiatric interview or followup, then indeed that resource could be available too. Just like in any other case.

Q Would he perform any laboratory tests?

A Indeed I think he should.

Q What laboratory tests should that be?

A That should be a urinalysis for toxicology, looking for all substances that are commonly abused. For example, methadone, for one; heroin, which you can't find, of course, in the urine--it is excreted as morphine--

THE COURT: You would find evidence of morphine?

THE WITNESS: Yes, you would, if he had used heroin.

First let me go back. I think the first thing to do would be to find out whether he is being treated for any disease entity that would require him having an opiate-like substance or one of the substances that is a controlled substance. Then from that point, once I found that out, then I would go and give him a urinalysis, determining what he might have in his urine. And the specific drugs that I would look for would be the opiates, the barbituates, the amphetamine-type drugs, the phetathiazines, I indeed would look for glutethamide, possibly. Demerol, dilaudid--

Q In other words, all substances commonly abused?

A All substances commonly abused.

Q Can they all be tested for? Are there procedures that detect them?

A All except cannabis, or marijuana, delta-9-tetra-hydracanavanol. There is no--

Q That is a medical term for marijuana, is that correct?

A The active chemical ingredient in marijuana.

Q Would you also screen an individual for alcoholism?

A I don't see how you can very well do that, but indeed I would.

Q How would that be done?

A In a urinalysis, I just think it's a waste of money to--

Q It can be done by other means, other tests?

A Of course. I think by history, by appearance, I'd look for spideryangyomata.

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

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Carl A. Peazer, et al.,

vs.

New York City Transit Authority

Defendant.

---------------------------------------x

:Before:
:HON. THOMAS P. GRIESA,
District Judge

72 CIVIL 5307

New York, January 27,28, 1975

STENOGRAPHER'S MINUTES

BEST COPY AVAILABLE

AFTERNOON SESSION

(3.30 p.m.)

* * *

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PAUL EUGENE KERSON, called as a witness on behalf of the defednant, being first duly sworn, testified as follows:

DIRECT EXAMINATION

BY MR. DUNN:

Q Mr. Kerson, by whom are you employed?

A City Councilman Carter Burden.

Q In what capacity are you employed by Councilman Burden?

A I am a part-time legislative aide.

Q How long have you been thus employed?

A Well, I was -- I worked there after the first summer of law school, the first year of law school in the summer of 1973 full-time, and thereafter part-time. Since then continuously.

THE COURT: Are you in law school now?

THE WITNESS: Yes, I am. A third-year student at Columbia Law School.

Q Did you, as part of the duties of your position, take part in an investigation for methadone maintenance treatment programs in the Greater New York area?

A Yes, I did.

Q When did you take part in this investigation, during what period of time?

A The largest part was between June and August of 1973, and then I conducted further investigations during the fall of 1973. And then continuously after that I haven't been investigating, but I've been sort of responsible for whatever goes on in Mr. Burden's office relating to this issue.

Q Would you tell us, please, precisely what you did in connection with this investigation?

A Well, myself and Mr. Jim Shaw, wh is a classmate of mine, Peggy Kerry, who worked there at the time -- I guess the three of us -- by myself mostly --

THE COURT: All law students at Columbia?

THE WITNESS: No, Peggy was a full-time employee of Carter Burden.

THE COURT: I have got to get these names. Just a second.

THE WITNESS: Peggy Kerry is K-e-r-r-y and Jim Shaw is S-h-a-w.

THE COURT: All right. Go ahead.

THE WITNESS: They had other responsibilities, but my responsibility was to investigate how Government regulates methadone clinics in the five boroughs and how these clinics are funded.

Q What did you actually do in the course of the investigation?

A The third thing I did was over the course of the three months I conducted 31 interviews with every Government official who would see me, who had any relation to methadone treatment, which included Federal, State and City officials in all varieties of agencies. I took a trip to Albany and one to Washington as well to see them.

Q Do you have with you a list of the persons whom you saw?

A Yes, I do, I do.

And then following that I visited 13 methadone clinics of which ten I actually walked through the facility itself. That occurred in September and October.

Then --

Q Do you have a list of those 13?

A Yes, I have a list of those, yes. Then we had three hearings in the fall of 1973 about -- what I tried to do was bring out everything they told me. We tried to get many of these people to come to the hearings, and indeed they did, and it was fairly productive.

It resulted in a bill which we proposed, and that bill is still pending. There was a hearing on the bill in October of 1974 and --but the results are still inconclusive.

Q Are you saying that there was a bill that resulted from --

A From the work of -- the work that I did. The bill is Intro. No. 569.

Q I show you Defendant's Exhibit for identification V, and ask if this is the bill to which you are referring?

A Yes, this is it. This is it, yes.

MR. DUNN: I offer this, your Honor.

MR. BALBER: Objection.

Your Honor, there has been no foundation laid.

THE COURT: Let us hold off with the bill. It may have relevance, but I assume you are going to interrogate the man about his observations and first-hand knowledge, and let us get that first, please.

Q Referring to the bill which you addressed yourself to, the legislative findings, that narrate that the methadone programs are frequently poorly supervised. Is this one of the conclusions that you reached from your investigation?

A Well, I have to qualify that.

MR. BALBER: Objection, your Honor.

THE COURT: Sustained.

Let us just not waste time. He walked through ten methadone clinics; he visited 13. Now, I assume he has got some personal knowledge so that we do not have to have this roundabout method of getting at things.

MR. DUNN: I will be glad to do it that way, your Honor.

THE COURT: Okay.

Q May I have the list of persons with whom you conferred?

A Okay.

Q The list of the methadone treatment programs you visited.

A I will give it to you, but then it will be difficult for me to testify.

THE COURT: Mr. Dunn, come up and work with him. You can stand with him or work with him and do anything you want to do as long as you can be heard.

A This is the list of people I saw on this page. This is the list of clinics I visited on this page. If you can't read my handwriting, I'll just read it for you.

Q Suppose you go down the list of clinics that you visited and tell us what, to the best of your recollection at this time, you recall having seen or what information you garnered at each of the clinics.

THE WITNESS: Your Honor, before I do that, can I say why I chose which clinics I visited?

THE COURT: Sure.

A We were looking for abuses because we had a lot of neighborhood complaints, which is in fact the reason that myself and Mr. Shaw were hired, because the upper East Side has a lot of methadone clinics and there were a tremendous number of neighborhood complaints about loitering of methadone patients.

So they kept urging Councilman -- the community rgoups kept urging Councilman Burden to find some solution to this problem, so he decided what he would do is start an investigation. And he hired myself and Mr. Shaw to do it.

Later that's what led to the formation of the committee, the act that because of us he was so knowledgeable about the topic already.

So we chose to visit clinics where we knew there were problems, and some of the clinics we visited were supposed to be the better clinics so that we could have some basis for a comparison.

Q Suppose, Mr. Kerson, bearing in mind your explanation, can you just go down the list starting with No. 1, give us the date of your visit, what you observed and continue on?

THE COURT: I want to get this straight. You selected some clinics that you had complaints about, right?

THE WITNESS: Well, either -- because -- I had done the interviewing first, so from the interviews, you know, there's this methadone maintenance thing is a very big deal. It's almost a sub-culture within the medical profession, and there's a lot of, what should I say, rumors and talk and so forth that goes back and forth as in any discipline or field or sub-field or whatever.

So I, you know, from all of these interviews, I began to know which clinics had good reputations and which did not. So we specifically chose some really poor ones to visit and some really good ones for a comparison. I really didn't see an avererage methadone, that's what I'm trying to say.

THE COURT: All right.

A Now I will go down the list if you want me to.

Q Would you tell us, please, was it a clinic that you chose because it was reputed to be a good clinic, or one that you thought was poor?

A All right. The first clinic that we visited was on September 21, 1973. The Addiction Research & Treatment Corporation, ARTC it's popularly known as. They're in Brooklyn, and they have 11 clinics in their operation.

THE COURT: What was the address of the one you visited?

THE WITNESS: 447 Lenox Avenue in Manhattan. And it turns out they were just building this clinic, and there was nothing really to see.

So we spoke with the guy who was going to be the director, a Mr. Smothers, but the building was just under construction so there was really nothing that we could see.

Q Did you choose the ARTC clinic because you thought it would be an inferior clinic or a superior one?

A Yes, there had been a Comptroller's report, the City of New York, the Comptroller, which was then Mr.

Beame, I think, that had criticized --

MR. BALBER: Objection, your Honor. It is hearsay.

THE COURT: Yes. I am willing to hear just in general why you visited a clinic, but I think from now we will limit it to your first-hand observations.

I take it you went to ARTC because you thought there had been a complaint?

THE WITNESS: That's right.

THE COURT: All right. But you really were not able to see anything, right?

THE WITNESS: That's right.

THE COURT: Let's go on to the next one.

A The next clinic we visited was one which had a very, very bad reputation and has since closed in fact. The Hausknecht-Shields Clinic.

THE COURT: Is it two words?

THE WITNESS: Yes, it is. It is named after the two doctors who owned it. H-a-u-s-k-n-e-c-h-t hyphen Shields, S-h-i-e-l-d-s.

Before I go into that --

THE COURT: Is Hauskneckt one word?

THE WITNESS: Yes. There's a Dr. Hausknecht and there's a Dr. Shields, and they own this clinic. It's now defunct, but they did own it.

Q I think Hausknecht is one word.

A Yes, it is. That's what I said.

THE COURT: When did you visit that?

THE WITNESS: Also September 21st. And it's at 13 West 190th Street in the Bronx. And this clinic, which is now closed, I should say, was in very poor shape. The building looked like it was falling down and they were dispensing methadone from the basement, and there didn't appear to be adequate personnel.

But that was, I should emphasize -- had one of the worst reputations in the city. That's why we went there.

Q When you say there were not adequate personnel, what do you mean?

A I didn't see that many people working there.

Q How many people were working there?

A Four that I saw.

Q How many patients did you see?

A About 15. There was a line of people waiting at the window.

Q Then, did you ask anyone if there were other personnel working there?

A Yes, we interviewed the administrators, Mr.

Al Wald, and Mr. Lou Liuzzo, L-i-u-z-z-o, I guess.

THE COURT: More of what you observed.

Did you observe, were they doing anything getting the drug administered at the window?

THE WITNESS: No, that was it.

THE COURT: Were any tests being administered?

THE WITNESS: No, nothing.

THE COURT: Was urine analyses being taken?

THE WITNESS: Nothing.

THE COURT: And no counseling services in evidence?

THE WITNESS: Not that we could see, although Mr. Wald and Mr. Liuzzo claimed they did all that stuff that you just described.

THE COURT: But you did not observe it?

THE WITNESS: No, I didn't observe it.

Before I continue, I should say that there are three kinds of methadone clinics in the city. There are private methadone clinics, what I call the quasi-public methadone clinics, and the clinics operated by the City Government through what was then the Health Services Administration --

THE COURT: Private is the quasi?

THE WITNESS: Yes. Three kinds.

Well, these numbers are old, but they're approximately right. There are 24 private clinics, about 90 quasi-public clinics, and about 40 City clinics.

And we tried to visit some of each kind, and I should say that we found the largest number of what I would consider bad clinics among the private ones, although some of the private ones were good.

The next one we visited was on September 28, 1973. The first clinic run by Dr. S-a-c-o-l --

THE COURT: You are a little fast for me, and I am sure you are too fast for the reporter. Give me the third clinic again.

THE WITNESS: The S-a-c-o-l-i-c-k Clinic, at 2367 Second Avenue in Manhattan. And we visited with a Mr. Rizzo, who was the administrator.

Now, that clinic looked a lot better. There again was a dispensing window with somebody dispensing the drugs and a line of people, but in the back there were what looked to be like private consultation rooms, and there were people consulting with counselors.

THE COURT: This was a private clinic?

THE WITNESS: This was a private clinic.

THE COURT: Of course, the Hausknecht-Shileds was a private clinic?

THE WITNESS: Exactly. The private clinics are usually named for the doctor that operates them. Because the law -- as far as I know, the law considers, and the doctors consider, this to be their private practice. They don't regard it as a clinic so much as they regard it as their medical offices.

THE COURT: Just slow down a little bit. The Sacolick Clinic had a window for dispensing drugs?

THE WITNESS: Right.

THE COURT: And what else did it have?

THE WITNESS: It had, well, it looked like private consultation rooms for patients to meet with their counselors, and in fact there were -- it looked like that was going on. And it looked -- it was a lot cleaner and more well put together, placed, than the Hausknect one.

THE COURT: We have heard them that one of the essentials is the conduct of urinalysis tests.

THE WITNESS: Right.

THE COURT: So the drug abuse can be detected if it goes on.

Did you look to see whether there was facility for giving the samples and testing the samples?

THE WITNESS: No, I didn't look for that. Mr. Rizzo told me that they did indeed have that. He told me that, but I didn't see it.

THE COURT: How big a place was this?

THE WITNESS: About half the size of this courtroom. It is long but like half the width.

THE COURT: One floor?

THE WITNESS: The second floor of a two-story building.

THE COURT: How many employees did you see in evidence?

THE WITNESS: It wasn't clear to me who was an employee and who was a patient, but there was certainly Mr. Rizzo and there were several people, I am not sure maybe two or three or four in sort of a dispensing room with, I guess, it was, some sort of wire around it that was dispensing the drugs.

There were, like in each of the counseling rooms, there were three or four of those rooms and in each of those rooms, either the door was closed or there were two people in it.

THE COURT: Did you find out how many patients they had a day?

THE WITNESS: I probably did but I don't remember.

THE COURT: How many patients did you see?

THE WITNESS: It looked like there were ten people waiting on line and in each of the rooms, there appeared to be two people. I assume one was an employee and one was a patient.

Again, on September 28, we visited the ARTC clinic --

THE COURT: You visited the Sacolick Clinic?

THE WITNESS: Yes. The next one we visited. an ARTC clinic, at 149 West 124th Street in Manhattan and we spoke with Anthony -- when I say we, I am referring to myself and Mr. Shaw.

THE COURT: Who did you speak to?

THE WITNESS: Anthony Miles who was the director. That clinic is in the basement of a warehouse but it just had been recently been remodeled. One of the things I had heard about ARTC was that they had a great deal of Federal money and was misallocated, so that is what we were looking for in the ARTC clinics rather than any kind of therapeutic abuse and, indeed, this was a well appointed clinic. The walls were freshly painted in an artistic way and it was big. It was a big clinic . Much bigger than this courtroom. It was the whole basement floof of a warehouse. There were two entrances, one on 124th Street and one on 125th Street so the thing was like a whole block long.

You went through these halls and there were a lot of different rooms. I wasn't sure about the purpose for any of these rooms and there didn't appear to be that many people there.

Again, I didn't get much of a chance to see anything there really because Mr. Miles just ushered us into his office and we interviewed him and he told us all about the clinic, but it certainly was a clean place and it looked like -- well, it looked a lot better than the Hausknecht Clinic and it was evident there was money to be spent on such things as decorating in ARTC.

The third clinic --

THE COURT: Did you see anything going on good or bad?

THE WITNESS: No. We just talked to Mr. Miles and he assured us everything was terrific. I didn't see any treatment there.

THE COURT: Was it a new clinic?

THE WITNESS: It appeared to recently remodeled.

THE COURT: Did you see any patients?

THE WITNESS: Again, it is hard to tell who is a patient and who is not. There was a day room where several patients were playing cards. I think they were patients. I am not sure.

THE COURT: Did you see anything else there? Did you see anybody getting drugs administered?

THE WITNESS: We visited the dispensing room of that clinic that had a woman who was dressed as a nurse, in a white uniform behind the counter which did not have any fencing or anything like that. She appeared to be the dispenser.

THE COURT: Were there people getting methadone from her?

THE WITNESS: If there were, there were only one or two because I don't remember clearly. Remember, all this was a year and a half ago.

Also on September 28 we visited the City Clinic at 264 West 118th Street and we spoke to Shirley Rushing and she was very reluctant to talk to us. She just didn't want to talk to us, but this clinic was in a City Health Department facility.

In the 1950s, apparently the Health Department built a lot of neighboring health facilities so this was a City building designed for health treatment so it looked like exactly what it was, something like a cross between a hospital and a school. There was a big waiting room and a window and a long bench -- it was built into the room for deciding who gets to see who next and there were a lot of those small rooms used for either administering the drug or consulting with a counselor, but the place -- there were some patients waiting there but it seemed to be fairly empty.

I should add most of the clinics we visited it was in the late afternoon and they are not too busy and we did that because we could talk to the people and also because we went to school in the morning.

So, I didn't necessarily get an accurate picture of how things were every visit. I mostly depended on what the director would tell me.

THE COURT: They had the big waiting room?

THE WITNESS: Yes.

THE COURT: Did you see any small rooms?

THE WITNESS: Yes.

THE COURT: Was there a lab facility?

THE WITNESS: It is my understanding that most methadone clinics contract labor services. They will have a contract and pay money to a private laboratory to do all the laboratory work and the only thing they will do in the clinic itself is collect the specimens which I guess is not the kind of thing you would see.

THE COURT: The City Clinic was public and ARTC?

THE WITNESS: That is quasi-public. It is a non-profit corporation that gets substantial grants. It is run by Dr. Benjamin Primm and its headquarters are in Brooklyn and they run 11 clinics.

Then on October 1st I went to Dr. Sacolick second clinic at 1175 Park Avenue and I saw Dr. Sacolick himself and this looked like a doctor's office. It was the only one I saw that actually looked like a doctor's office. It is around 90th-something Street.

THE COURT: What was the date of that?

THE WITNESS: October 1st, 1973.

I spoke with Dr. Sacolick at length and that clinic looked like a doctor's office. Patients were sitting in the patients' room. There were rooms.

I am not sure about this but I think Dr. Sacolick conducted a regular medical practice from there as well, though I am not sure. It looked like he was or had been -- recently doing it.

Then on October 8 I went to the Lower East Side clinic, I am not sure of the address there, but it is directly behind the Criminal Courts Building, about two blocks north and that is a City clinic and it was run by a man named Myron Greenberg.

This clinic didn't look at well appointed or anything but I was impressed with Mr. Greenberg. Of all the people I saw, he seemed to be the most knowledgeable and most on top of what he was doing, even though his facility didn't look that good and there were rooms for consultation, although again -- and there was also a dispensing sort of area and people sort of waiting around to get their medication. I didn't really see -- I saw one consultation going on but that was it.

On October 16, that was a big day. That was when we had our infamous bus tour. What we did was, we wanted to emphasize to the other members of the City Council and to the press the wide disparity in how methadone treatment is conducted so there was a Public Works Department bus and we had I think five councilmen and seven or eight members of the press and followed by a television truck and we proceeded to see three methadon clinics.

We took the crew up to the Hausknecht Clinic and we barged in on Dr. Hausknecht who was again running the shoddy kind of operation I described when I saw him December 21 and of course they were surprised to see us since we didn't announce we were coming except an hour before and Mr. Burden questioned him in front of the members of the press and he admitted he was making more than $100,000 on this operation.

Anyway, there was a very critical article on him in the Post and on television and next week he closed the clinic.

THE COURT: What else did you do?

THE WITNESS: Then we went to the Kaye Clinic run by Dr. Kaye on East 92nd Street between Madison and Fifth Avenue and that was of course better than Dr. Hausknecht but the problem with that clinic was it was run in a very tiny, tiny office, two rooms which was hardly enough space to conduct a clinic. The reporters of course were very impressed with how small this was and that was the extent of going to Dr. Kaye's clinic.

BY MR. DUNN (Continuing):

Q Is Dr. Kaye's clinic still in existence?

A As far as I know it is, although he is involved in a large dispute because he is trying to move. He realizes his space is too small -- since we have done the - study, all the private clinics formed an association. They have all tried to improve as best they could because we had recommended that private clinics be ended, so they have really made a wholesale effort to improve their treatment facility.

Dr. Kaye is trying to move to the west side where there are virtually no methadone clinics between 113th Street and the Chelsea area because community groups on the west side have been vehement in that they don't want them there. So, there is a lot more on the east side.

Dr. Kaye wants to move to the west side to 101st Street, although I am not sure and the community is fighting him desperately and maybe I will get into this later, I don't know, but there is a tremendous bureaucracy involved in trying to move a methadone clinic. You have to get the approval of anywhere from, depending how you count them, seven and 15 agencies. He is trying to move but he can't. He has just been stymied so he is still there. He is there not because he wants to be.

After we went to Dr. Kaye, we went to what we conside to be one of the best methadone clinics, the one at New York Hospital, which is not really in the hospital but a block away on East 71st Street and Second Avenue and they had also recently redecorated. They had facilities for examining patients medically and it had consultation rooms and a group therapy room.

THE COURT: Let me go over that again.

They had a drug dispensary?

THE WITNESS: Yes. They had a room which looked like it was equipped for examining a patient. They had several consultation rooms. There were about four doctors there and Dr. Leonard Heimoff is the head of it. He is an older doctor but he has been involved in this field, according to him, anyway, longer than anybody, so he is regarded as something of an elder statesman in the drug world.

Everybody was very impressed with him. One of the councilmen, Councilman Golden saw all the doctors wearing white coats and thought that was an improvement.

That was pretty much the extent of my visits to actual clinics. I had three other visits where I visited methadone clinics but didn't go in the clinic area itself.

Q Will you tell us about those and why you did not go into the methadone clinic?

A The first two were on June 25, 1973 and August 8th, 1973 where I visited the executive headquarters of the Bernstein Institute which is a division of Beth Israel - Hospital. From that central location they run I think 38 other methadone clinics.

THE COURT: Exactly where did you go and when?

THE WITNESS: On June 25, I saw Dr. Harvey Gollance.

THE COURT: This is 1973?

THE WITNESS: June 25. I saw him in his office.

On August 8th I saw Dr. Gollance and Mr. Levine in Mr. Levine's office. Mr. Levine was in charge of the financial aspects of this operation.

THE COURT: You saw Gollance and who?

THE WITNESS: Levine.

THE COURT: What is his first name?

THE WITNESS: I don't have it here.

THE COURT: But he is the financial man?

THE WITNESS: Right. I was very interested in that because Beth Israel has the largest budget in the operation.

THE COURT: Bernstein Institute is a methadone facility?

THE WITNESS: It is three things. It is itself a methadone clinic. It is the central administrative headquarters for a group of 38 clinics which Beth Israel administers and it also has specialized facilities that all of those 38 clinics can take advantage of. It is very well regarded. This is the center for this kind of treatment. This is it and they hold conferences there and conventions and experts speak there. They are very much the leaders in the field there and they have centralized services, centralized medical services, a centralized detoxification service, centralized socialization service, all in the Bernstein Institute for use by all of their other clinics or 37 clinics.

THE COURT: What do you mean by centralized, they send people around or people come there?

THE WITNESS: It is the Bernstein Institute.

THE COURT: Centralized facilities for what?

THE WITNESS: They have 37 other clinics. I think it is 37.

THE COURT: The thing I didn't get, centralized facilities of what kind?

THE WITNESS: There is a centralized medical facility for methadone patients with other medical problems or more serious than they can take care of in a local clini

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There is a detoxification facility and a centralized counseling facility for I guess more serious problems and patients go there by referral from other clinics in their cartel, if you will, of clinics because they run a great deal. They are the largest operator of what I call the quasi-public clinic and they also have the highest Medicaid reimbursement. At this time they got $14.69 per patient per day form Medicaid.

THE COURT: Medicaid reimbursement is in addition just to direct subsidies?

THE WITNESS: Yes. Direct subsidies is a much smaller part of the fund.

THE COURT: We had testimony this morning from Dr. Primm and he said he got about $5 million total Federal and City aid per year.

Is that a direct subsidy?

THE WITNESS: He is the exception to the rule. Of all the groups of clinics, he has the most heavy group of grants.

THE COURT: Direct grants?

THE WITNESS: Yes.

THE COURT: Let's say Beth Israel, how are they financed?

THE WITNESS: They have grants from the Drug

Abuse Control Commission which is a State agency and from I think, what was the National Institutes of Mental Health.

THE COURT: They have a grant from the State?

THE WITNESS: And from the Federal Government but the bulk of everybody's funding with the possible exception of ARTC is from Medicaid.

pm BY MR. DUNN:

Q Mr. Kerson, will you tell us --

THE COURT: One second.

BY THE COURT:

Q If a person goes to a drug-free program -- Phoenix House -- are you able to tell me if he can get Medicaid?

A I don't know about the drug-free program -- no, I did not research that.

Q But if you go to a methadone program you can get Medicaid?

A Right. That was the biggest -- unfortunately, that was the biggest abuse that we found, and that was the most frustrating part, being a City agency, there is very little we can do about Medicaid, which is very largely State and Federal money; because what happens is the reinvestment rate, you reimburse per patient per day basis, and it ranges all the way from $4 to almost $15 for the exact same treatment.

Q Who gets the biggest?

A Beth Israel gets the biggest.

Q Why do they get it?

A At the time they got $14.69. It think it has been raised since then.

Q This was back in 1973?

A '73, the summer of '73?

Q That is $14.69?

A Every time a patient walks into the door.

Q For a visit?

A For a visit, so they go to the Bernstein Institute with all their specialized facilities and their additional doctors and additional social workers.

Q This varied, is that right?

A Tremendously.

Q And what is the lowest?

A Well, at the time it was $4.50. All the private doctors only got $4.50, because when I went to Albany to see Don Wheatley -- I went to see him at the end of August of 1973. He was in the Division of Health Economics of the State Department of Health, and he and Mr. George Cook are in charge of setting Medicaid reimbursement rates for methadone clinics, and it was beyond me to figure out what rationale he used to determine who gets what. He couldn't explain it to me that well either, but it seems that except for the private clinics which are flat rate, everybody else is reimbursed on a cost basis -- that is, whatever they say their expenses are; they go through and disallow some of them, and then to the appropriate division they come out with what their appropriate rate should be.

So Beth Israel -- let me backtrack a little more -- this was first started as an experiment by Dr. Vincent Dole of Rockefeller University, and he had experimented with a few hundred --

Q We have been through that.

A You have been through that?

Well, Beth Israel is the next step. They were the first people to set it up, because they continued to have the largest costs, and they had the biggest rates. That is how we found out what they are doing with their money, and that was unsuccessful, and we did find out why their rate is so much higher.

Q Then you asked Mr. Levine --

A Right.

Q -- the financial man in the Bernstein Institute --

A Right.

Q -- about his expenditures?

A Yes, I did, but he was very reluctant to tell me.

Q Did you get any information?

A No, I did not, but subsequently I think when I went to Albany, I chased down a man in the State Comptroller's Office, and he finally agreed to show me the Beth Israel budget, and he sent it to me but with all the names of the employees all blocked out so that I couldn't tell if there was any overlapping staff; but anyway I could see that they spent all that money.

Q Does any agency of the State check on the validity of whatever financing is done -- in other words, whether they deserve the rate or don't deserve the rate and how the spend the money?

A So far as I could see, nobody.

Q Nobody checks?

A No.

Q It is State and Federal money that goes there; right?

A Yes. I think there are people who are supposed to check.

Q Who are supposed to check?

A That is right. That is whatever the Medicaid bureaucracy is -- it is a five-agency -- really six-agency operation. There is some division -- let me see if I can get it straight.

There is a division of the Department of Health & Welfare which gives the money to the State Department of Social Services.

Q You start with --

A HEW.

Q -- HEW, and they give the money --

A To the State Department of Social Services.

The City Department of Health is in charge of monitoring -- the City Department of Health, Medicaid unit, is in charge of monitoring it.

Q The Department of Health?

A Right, the City Department of Health, Medicaid, although they have no enforcement function, what they do is if they find what they consider to be an abuse in over-billing, they will tell the City Department of Social Services not to issue the check.

Q Do they investigate -- does the Department of Health investigate?

A It is not exactly the Department of Health; it is the Medicait unit of the Department of Health, which is a sort of separate unit.

Q Does the Medicaid unit of the Department of Health investigate the expenditures of the money by the methadone clinics?

A Well, they don't go clinic by clinic. What they do is, when they have a report of an abuse, of financial abuse, they will call in the doctor concerned and question.

Q Okay. So they investigate and they can then hold up the money.

A Right.

Q And who actually issues the money for Medicaid reimbursement?

A The City Department of Social Services.

Q And they get it from the State Department of Social Services?

A The State Department of Social Services.

Q Okay, let me make a note.

The City Department of Social Services, they actually pay --

A Right.

Q So if you are a clinic and you want to get Medicaid reimbursement you apply to the City Department of Social Services, is that right?

A I'm not sure exactly how you apply.

Q But anyway they do the paying.

A They do the paying; they issue the actual checks, and from what I found out it is a very difficult procedure to stop. In other words, the checks flow automatically.

Q Well, we can't get too deeply into this, but I did want to know --

A There is more, your Honor. The State Department of Health suppposedly supervises the City Department of Health in their inspection, and more money is added each time -- like Federal contributions are 50 per cent, the State contributions are 25 per cent and the City contributions are 25,

Q To Medicaid?

A Right. That is why the money keeps flowing down. Did I say 50-25-25?

Q Right.

A Yes.

Q In other words, that is, who pays every dollar of Medicaid reimbursement?

A Right, and from what I could determine, Medicaid reimburses -- well, these figures are very rough but I could not get any kind of total figures as to how much money was spent. But I went through a complicated procedure to estimate it.

In 1972 I concluded that there were $69 million of Government money from all three levels spent on methadone treatment, of which about $42 million came from Medicaid.

Q In New York City?

A In New York City, the five boroughs.

Q How much on Medicaid?

A 42 came from Medicaid -- 42 million of the 69 million total, but again I should caution you that that is only an estimate.

Q Did you ever check anything about whether any governmental unit monitors these clinics to see if they are abiding by the Federal and State regulations as to how they are conducted? I am not talking about the finances.

A Right. I spent my time focusing on that part of the summer --

Q July of 1973?

A Right. There are a lot of agencies which do that. That is what we knew to be the problem. They kept tripping over each other, but the first agency and the most important one is --

Q When did you spend time doing this?

A July and August of 1973, and I also should caution you that since then things have changed, and the agencies which I found inefficient then got more efficient.

MR. DUNN; I move to strike that, your Honor. There is no showing that he has --

THE COURT: You cannot cut it off at this point. He is testifying, and I will let him go into that, in order to get the whole picture the best he knows it.

THE WITNESS: Right.

BY THE COURT:

Q Let us start with what you did in July and August 1973?

A Okay.

Q You were intent on seeing what agencies monitored the conduct of the clinics -- right?

A Yes. It is very involved, so please bear with me.

Q All right, go ahead.

A The first part is the Medicaid part -- I tried to explain that.

Q Yes.

A Then the Food & Drug Administration, which is a division of the Federal Health, Education & Welfare Department, they have detailed regulations that were issued in the Federal Register on December 15 of 1972, I think, and they are responsible for enforcing those regulations which are -- well, theycall them minimal regulations, jointly with the State Authority. In other words, they call on every state to keep a State agency to do it, but in New York State they were having a bureaucratic conflict between the State Health Department and what was then the Narcotics Addiction Control Commission -- it is now the Drug Abuse Control Commission, as to who was going to be the State Authority. So we were like one of the last of the states to name a State Authority, so for a long time -- I guess a period of a year or more -- yes, I guess a year or six months to a year -- after these regulations were promulgated New York had no State Authority. So the Food & Drug Administration, which was sitting on these applications, they gave everybody interim approval, which is not the situation -- well, it really resulted in no regulations at all.

Well, finally Governor Rockefeller named -- then Governor Rockefeller named the Drug Abuse Control Commission to be the agency.

Q When was that?

A Well, there is a debate about that, but it must have been right around the time I started working on this, which was in the spring or summer of 1973.

Q All right, the summer of 1973; and the name of that agency?

A It was then the Narcotics Addiction Control Commission -- now it is the Drug Abuse Control Commission, and he put up or somebody put up Dr. Seymour Joseph in charge of this particular division of the Drug Abuse Control Commission -- the DACC.

Now I found anyway at the time that he was dragging his feet. They did not write their regulations right away. They did not hire a staff right away. Since then I talked to him at various intervals and they gave gotten the regulations written, and they have hired a staff, and they are trying to do a better job than they did then, which I found at the time was no job at all.

Q In 1973?

A In 1973, the summer.

Q He could hardly have been appointed then.

A Well, he was director of the Office of Pharmaceutical Control and had been responsible for other things. It wasn't like he was, you know, just hired. It was an existing bureau which got a new function, but meanwhile the New York State Health Department was not satisfied with their bureaucratic measures were getting the job done, so they declared all methadone clinics to be hospitals within the meaning of Article 28 of the State Public Health Law.

Q This was a New York Department?

A New York State Department of Health, and they have the power to regulate hospitals, so they started to regulate methadone clinics pursuant to their power to regulate hospitals, and that called for another four agencies -- the Comprehensive Health Planning Agency -- CHPA -- the City is required to write a report about the need for a given clinic.

Then they passed their report on to the Health & Hospitals Planning Council -- the HHPC for Southern New York --

THE COURT: I don't believe we want to go through that.

A All right.

Q In other words, when the State Department of Health attempted to get into that, then that invoked the services of --

A For other agencies.

Q For other agencies?

A Yes.

Q What did they do -- inspections or certifications or what?

A Well, the first three wrote reports based on -- I don't know -- hearings, I guess. I wasn't aware that they actually did investigations but I guess they must have -- but I am not aware of it.

Q Well, the question I am interested in ultimately is, I have been told that there are Federal regulations and State regulations --

A Uh-huh.

Q -- and the existence of those regulations is some assurance as to how the methadone clinics are conducted, namely, if you look at a regulation and it says something is supposed to be done, then I am supposed to conclude it is being done.

Do you get me?

A I got you.

Q All right. Now I want to know if I can infer from the existence of the regulations the fact that something is being done, which would seem to me that would depend on whether somebody is checking that it is done.

Now you made an inquiry in 1973, and at that time I take it the situation was -- well, who was supposed to be the -- does the FDA have its own people out doing checks or do they gather records of their own independently of some State agency?

A Yes, they operate wholly independently, so far as I know.

Q What do they do? Do they have men?

A They have an office in Brooklyn, a regional office of the FDA, and I spoke with -- who did I speak with? Eugene Cleff -- no, I spoke to George Gerstenberg.

MR. BALBER: Your Honor, I do not wish to cut of any inquiry but this witness' observations are obviously based on hearsay. The FDA does not do inspections in New York State any more. They are totally done by the State agency and the Drug Abuse Control Commission.

THE COURT: The State agency.

MR. BALBER: Obviously this witness has no knowledge, and we are now getting into shaky hearsay, and I object to that.

Q Well, let me ask you this -- I do not want you to bring in these statements of somebody else but what do you know about what the FDA does? I mean, have you seen anything or did you just talk to that fellow in Brooklyn or what?

A Them, and I spoke to their superiors in Washington -- in Rockville, Maryland, which is a suburb of Washington, D.C. There is another Federal Bureau, the Drug Enforcement Administration.

Q Aside from the FDA --

A Yes. They are part of the Justice Department.

THE COURT: Mr. Balber, it would be of interest to know what the FDA does, but I do not want to have it come in other than in the regular way.

Do you have any suggestions?

MR. BALBER: If the Court please, we can call the head of the Methadone Compliance in Washington. His name is Mr. Buddy Stonecipher. We have had communications that might be helpful to the Court, but the FDA no longer does the direct inspection function; it is delegated to the State agency.

BY THE COURT:

Q Is that correct or do you know?

A I have no knowledge of that.

Q Well, if the FDA -- we are interested in the person who obviously knows --

MR. DUNN: At the present time, your Honor, think I may be able to clarify something. What Mr. Balber says is correct. That was my impression. The FDA does not at the present time investigate that; they referred to the DACC. The head of the DACC has been subpoenaed and will appear tomorrow as a witness.

THE COURT: I think you are in agreement. We do not need anybody from the FDA obviously.

MR. DUNN: We spoke to Mr. Stonecipher, too, your Honor. I do not think his presence is essential.

THE COURT: Very good.

If you are going to have a gentleman from the State agency, then I think we can rely on him to tell us about the extent of his inspection -- unless this gentleman has some information along the line that you want to bring out or that he knows about.

What do you want to do?

MR. DUNN: With the exception of one statement that appears in the report prepared by this gentleman, I think I would like to wait for Dr. Joseph to testify.

THE COURT: Fine. Well, can you pick it up? i went through the financing thing with him and the business about the State inspection.

What else do you want to cover?

BY MR. DUNN:

Q Mr. Kerson, the last program in point of time that you visited was what?

A That -- it seems I did not finish that part of my testimony, but what I can remember is this, we had the bus tour and then that night I went to the Coney Island Hospital Methadone Clinic -- although I did not go to the clinic itself, I went to the hospital auditorium where the patients were having a meeting, and I observed their meeting and I spoke to them, so that was, if you will, my principal experience speaking to methadone patients.

Q What was the nature of the meeting that you attended?

A Well, these patients -- Coney Island is a middle-class neighborhood, and unlike most methadone patients, this group of patients was - well, they were older as a group. Rather than being in their 20's they were in their 30's and 40's, and they looked like people being working people.

Q Well, Mr. Kerson, what was the nature of the meeting? Was it a group of patients or a patient organization?

A Yes, a patient organization that was -- they wanted to -- it was an improvement group. They were seeking to improve conditions in the Coney Island Hospital.

Q And what conditions were they complaining about?

A Well, it is hard to say. It was a very disorganized meeting, but it seemed that they were complaining about -- well, they did not have the counselors to respond to their needs. They did not think the clinic was open long enough hours. The clinic was open only 11 hours and they wanted it open longer -- things like that.

Q Were they seeking the removal of the medical director?

A I believe -- yes, I think so. I don't remember the exact details of that, but they were --

MR. BALBER: I move to strike this.

THE COURT: Strike it.

What do we get from this?

MR. DUNN: The witness is testifying to what he saw.

THE COURT: He testified he heard some people complain about the medical director.

MR. DUNN: This apparently, your Honor, was an organized protest by the patients concerning the conditions at the treatment center.

THE COURT: Mr. Dunn, you know, the time is coming where we are going to have to conclude this case. If there are facts you want to bring out about the condition of methadone clinics, there are witnesses that you could subpoena or could have subpoenaed to tell me about that.

Now, this fellow has obviously done a very fine job on his study and it is very good of him to come testify, but he was not examining clinics at times when the patients were bound to be there and seeing the things that you might want to present.

So I am afraid his testimony again is -- it certainly adds something, but I cannot have facts proven by hearsay, and that is all there is to it.

So you have to bring out what he knows, what he saw, and then you have to rely on somebody else for the other things.

Q Mr. Kerson, did you, as part of your investigation, send questionnaires to each of the methadone programs in the City of New York?

A Yes, we did.

Q How many questionnaires did you send out, sir?

A Well, to every clinic, but I guess 153 or I think there were 157 at that time.

Q How many replies did you receive?

A Well, it's difficult to say. We got one uniform reply for all --

Q How many questionnaires were returned?

MR. BALBER: Your Honor, would you permit the witness to answer the question?

THE COURT: I was making notes.

You said you sent out 150 approximately?

THE WITNESS: Right.

THE COURT: And you got back what?

THE WITNESS: I was going to explain this.

We didn't get -- it's not like you could count it as a percentage basis. We got back one uniform response from the City Health Services Administration programs, and that's about 40 programs, and we got one response for that.

So I don't know how you want to count that. Then most -- I would say some of the private programs responded, most didn't, and most of the quasi-public programs did not respond.

Beth Israel did not respond. I looked at the pile that I had and there was no response from Beth Israel there, which is the biggest one. I couldn't give you an exact number.

Also, many of the things were returned half answered, so it was hard to say. It was an unsuccessful survey. That I can definitely say. And we did not use it to conclude anything. We just read them with interest.

Q Were these replies very detailed?

A No.

Q Was the questionnaire detailed?

A Yes.

Q On how many occasions --

MR. BALBER: I object. This is probative of nothing.

THE COURT: Let us drop the questionnaire. That is really irrelevant.

Q Was your investigation mandated by a resolution of the City Council?

A I don't remember exactly, but I believe so.

Q Did you, as a result of your investigation and the investigation conducted by other members of your staff, offer a report?

A Well, let me say this about that:

I prepared all of the notes and a rough draft, which is actually in the form of a detailed outline for the report, but I did not do the actual drafting of the report. That was done by a man named Terry Connally, C-o-n-n-a-l-l-y. who was at the time -- he had previously been two years before on Mr. Burden's staff. At that time he was a lawyer with Cravath, Swaine & Moore, and is now in the London office of that firm. But he did the actual drafting, although I did most of the research and prepared the outline from which he wrote the report.

Q You say he did the drafting. Was it a question of editing with respect to style, with respect to language?

A Yes, the outline was very detailed and included passages from my notes. You could call it a draft copy; maybe you couldn't. The final report is about twice as long as the document that I gave him.

Q I show you Defendant's Exhibit U for identification and ask whether this represents the substance of the report prepared by you as a result of the investigation which you and your staff conducted?

A This is the report written by Mr. Connally, the substance --

Q I asked you whether this is the substance of the report prepared by you.

A Okay. The substance is prepared by me, yes.

THE COURT: What is the document? What is the exhibit?

THE WITNESS: It's the report of the Special Committee on Methadone Treatment Programs of the City Council.

Q Are the statements contained in that report substantiated or were they substantiated by your findings as a result of your investigation?

A Can I explain that, my answer?

Well, I can't exactly give a yes or no answer because "findings" is a tough word for this. I tried to immerse myself in this topic as much as I could.

Q Let me rephrase the question.

Is there anything in the report that is at variance with what you found to be the truth during your investigation?

A Well, not exactly at variance, but the report is a political document, the idea was to focus on the abuses --

MR. DUNN: Your Honor, may I have the witness answer the question as posed?

THE COURT: I think --

MR. BALBER: I think he is trying.

THE COURT: Let us just get an explanation from him as to what this report is.

A It's not the kind of report you would prepare for law school or even for college. It was a -- the kind of report that is designed to convince other councilmen that a bill is needed.

In the research we focused on abuses because we knew there some. However, in the very beginning of the report we start out with a statement that:

"No other city in the world has so successfully transferred so many heroin addicts from dependence on an illicit drug treatment under legal auspices in so short a time."

From there, everything proceeds. We started with the assumption that methadone was a good thing, it was serving people, and it was worth preserving; but there were certain abuses which we felt had to be corrected by the City Government.

That was the conclusion, and the report was written to dramatize that conclusion by referring to the specific abuses that we found.

THE COURT: Was this a report to the Council?

THE WITNESS: Yes.

THE COURT: And the date of the report?

THE WITNESS: December 18, 1973.

Q It is December 20th, is it not?

A The copy I have -- oh, yes. We issued a mimeographed copy December 18th, but it was printed in the minutes of the Council on December 20th.

Q Let me ask you again, Mr. Kerson, is there anything in this report that is not in consonance with the investigation you conducted?

A Again, I find it very difficult to make a yes or no to that question.

Q Is there something in this report that is not truthful as compared to the results of your investigation?

A Yes. There was one sentence which I found.

Q Will you point that out to me, please?

A Page 11.

Q Will you refer, please, to th Council proceedings?

A Oh, I'm sorry. I don't know, in the Council proceedings it's in Section 2-A.

THE COURT: Is this part of Exhibit U?

MR. DUNN: Yes, your Honor, for identification.

A It's Section 2-A and it's about in the middle of 2-A, and the statements -- I can't point to it exactly. If you want me to look, I will.

Q Would you, please?

A All right.

Here, on page 743, the fifth line, it says:

"Only a very few of the 34,000 methadone patients in the city today benefit from the type of services provided to that first group of six hard-core heroin addicts."

Well, there the attempt is to provide those services to all of them.

Q Which services?

A Methadone treatment in all of its forms, if you will.

THE COURT: The rehabilitation counseling?

THE WITNESS: Right; that's right. The counseling and rehabilitation.

THE COURT: The statement there says that only a few of the present 40-odd thousand benefit from all of those services.

THE WITNESS: Right.

THE COURT: And you say that is not correct?

THE WITNESS: Right.

THE COURT: Okay.

THE WITNESS: Because I don't and we didn't have numbers; we didn't make an attempt to determine what percentage of the clinics have abuses or what percentage of the patients are getting bad treatment. All that we are sure of from this study is that there were abuses and there were patients who were being treated poorly.

As to how many there were, I don't know. We did think that there was enough to require a bill. But not -- that -- well, you can draw from that whatever implications you want. But that -- what I'm trying to say, I guess is that the report creates an impression that there are tremendous problems.

Now, there are problems but -- and there are tremendous problems -- but what percentage of the clinics have how much of the problem, I don't know.

THE COURT: Anything else, Mr. Dunn?

MR. DUNN: Yes, your Honor.

Q Does this report to the City Council represent the product prepared by you as a result of the investigation conducted by you?

THE COURT: He has explained to us exactly how it is gotten out.

Q Except with respect to the fifth sentence on page 743?

A Well, again, it's relatively -- there's nothing in there that is untrue, but it creates, I think, an impression and we talked about this at length at the time. It creates an impression that there is a lot more problems that I thought that there were.

But we did that for a purpose, and I didn't object to it at the time because we wanted to get people to pass this bill, which we think would make methadone treatment even better than it is.

MR. DUNN: Your Honor, I offer Defendant's --

MR. BALBER: Objection.

MR. DUNN: I haven't offered anything yet.

THE COURT: I think you were about to. Defendant's Exhibit U?

MR. DUNN: For identification.

THE COURT: All right.

Look, Mr. Dunn, I won't -- do you object?

MR. BALBER: Yes, your Honor.

THE COURT: Aside from that, I have a meeting. Some people have come in from out of town, and I want to get to them. I do not want to rule on that exhibit tonight, as I am sure there will be considerable controvery over it.

Do you wish to cross-examine Mr. Kerson?

MR. BALBER: Some limited cross-examination, yes, your Honor.

THE COURT: Well, I tell you, can you be back here tomorrow morning?

THE WITNESS: I guss so.

THE COURT: We will start at 10. You are going to have to adjust the schedule as necessary.

MR. DUNN: At 10 o'clock

* * * *

PAUL E. KERSON, having been previously sworn, resumed and testified further as follows:

CROSS EXAMINATION

BY MR. BALBER:

Q. Mr. Kerson, do you have any medical training?

A. No, none.

Q. What is the highest science course you have completed?

A. I took geology in college, and biology and chemistry in high school.

Q. Do you have any training in drug addiction therapy?

A. None.

Q. Vocational rehabilitation?

Q. None.

THE COURT: He never really calimed this(This is a waste of time.

Q. Mr. Kerson, you stated that you visited methadone programs in the fall of 1973, is that correct, your on-site inspections of these programs?

A. Right, in September and October of 1973.

Q. Have you made any first-hand observations of methadone programs since that time period?

A. No.

Q. When you visited those programs did you make any attempt to observe urinalysis procedures while you were there?

A. No, I didn't. It's my understanding that most ofthe lab work for that is conducted elsewhere. It's contracted out to laboratories.

Q. But you didn't observe the procedure. You didn't attempt to boserve the procedures?

A. No.

Q. Did you inspect urinalysis records during your visits to the treatment programs?

A. I wanted to but most of the clinics were not cooperative to that extent.

Q. Did you examine patient records during your visits to the treatment programs?

A. Again I wasn't allowed to see them, although I would have liked to and did ask.

Q. Did you observe patient record keeping procedures?

A. No, other than the fact that I saw file cabinets, I didn't see anything. I didn't look at any records.

Q. Did you make first-hand observations of patient-counselor ratios?

A. Other than what I described yesterday, no.

Q. Mr. Kerson, during the course of your investigations, did you measure the therapeutic success of particular methadone maintenance treatment programs?

THE COURT: He testified about what he did. There is a lot he didn't testify to. You could go on for five hours asking him all the things he didn't testify to.

MR. BALBER: I have no intention of going on ad infinitum. I simply want to indicate that to the extent the report is received, if it ever is, that it's not based on first-hand observations that Mr. Kerson made except during those visits which were very discreet and limited observations.

THE COURT: I assume -- it isn't an assumption -- the only activities that I would believe that this man carried out are the ones he testified to and activities he didn't testify to I assume he didn't c arry out.

MR. BALBER: One final question:

Q To the best of your recollection, have you testified completely in this case about all the first-hand observations that you have made in methadone maintenance treatment programs?

A. To the best of my memory, yes.

Q I would like to review for a moment how that report was written.

A. Right.

Q You made first-hand observations. You testified about that?

A. Yes.

Q You also interviewed a number of second persons, is that correct?

A. Right, I did 31 interviews, specific interviews where I actually wrote them up and I made these 13 visits that I testified to already, and I read numerous things.

Q You then summarized the first-hand observations about which you testified and the interviews, you forwarded them to another party?

A. Right, Terry Conley.

Q Thatperson had not done any first-hand observations; is that correct?

A. Not to my knowledge, no. Although he might have but I didn't know about it. I don't think he did because he was employed as an attorney for a law firm at the time.

Q Then from your notes, Mr. Conly wrote the report?

A. Correct. It was sort of a intermediate draft, if you will, that extended the outline I gave him; but he didnt follow it directly.

Q Did you ever have an argument with Councilman Burden about how the report was written?

A. Yes, we had several meetings, Mr. Shaw, Miss Carey, Mr. Conley, Councilman Burden, and myself where we discussed what the report should say. Mr. Shaw amd yself felt it should be more of an academic document and they didn't. Also we had some debate as to whether the distinction --

THE COURT: When you say they didn't, who was they?

THE WITNESS: Councilman Burden principally. There was some debage as to how much emphasis we should give the private clinics in the report.

Q. What decision was made about that?

A. That we should emphasize the private clinics and emphasize the abuses there.

THE COURT: Who made that decision?

THE WITNESS: Councilman Burden. It was his work and his report. We were just employees.

Q Was the decision made to delete citations to sources of information?

A. In the sense that it was not written with footnotes, yes. I wanted to do it with footnotes, but we ultimately did not.

THE COURT: Was that what you meant when you said you thought it should be more of an academic document?

THE WITNESS: Right. We had planned to write a final report, and we scrapped that. When we started writing the final report, Jim Shaw and I started doing it with extensive footnotes and citing every impression or fact, but that report was never finished because the committee, the Special Committee on Methadone Treatment Programs -- all the work was taken over by the Health Committee which Mr. Burden became chairman of. The Health Committee had other concerns, and we had other work to do, so we never did the final report.

Q So this document then was not intended as the final report?

A. It wasn't at the time, but ultimately it's come out to do because we never did all the work.

Q Was the report ever adopted or approved by the Special Committee on Methadone Maintenance or by the City Council Health Committee?

A. I guess I should say this: the way the committee structure works in the City Council is sort of a popular fiction. . There really aren't any committees the way there are in Congress or the State Legislature. It's controlled by the executive branch, by the Mayor and through him the majority leader..

The committees don't meet unless the Mayor and the majority leader want them to meet. To my knowledge, this special committee didn't meet unless we had meetings, and even then the majority of the members didn't show up. There were so many members of the committee that I didn't even meet.

THE COURT: What committee was this?

THE WITNESS: The Special Committee on Methadone Treatment Programs. I never met Mr. Gate or Mr. Biondillo. They never came to any of these hearings, an I never met them.

THE COURT: The question was, did they get accepted or adopted?

THE WITNESS: What I am saying, to my knowledge there was never another meeting of this committee.

Q You mean it was never on the agenda?

A. There wer no printed agendas.

THE COURT: There was no meeting?

THE WITNESS: To my knowledge. To my knowledge there was no meeting.

Q. Was the report ever adopted by the City Council?

A. To the extent it was printed in the record, whatever that implies, that is true.

Q. How does something get added to the record?

A. It's submitted by someone in authority to submit, and I guess Councilman Burden submitted it.

Q. Was that record similar to the Congressional Record?

A. As far as I know,yes. It may be somewhat different. I should emphasize the procedures in the City Council are lax, and it's frustrating to be involved with that institution .

MR. BALBER: If there was ever any question of the admissibility or probative value of the report, I think it's been answered.

THE COURT: You just finish your examination of this witness.

MR. BALBER: I am finished.

THE COURT: Any further questions?

REDIRECT EXAMINATION

BY MR. DUNN:

+ In addition to the 31 interviews and 13 visits to the methadone program, was there anything else you did to compile the information from where the report emanated?

A. I did some research. I read all the appropriate statutes and some law review articles and medical journal articles. The bulk of the work was those interviews. That was the most important thing, and I even went to Albany and Washington to seek out the appropriate officials.

Q. Did you not send 155 or 157 questionnairs?

A. Right.

Q. And did you not also atend the public hearings that were held by the committee?

A. I arranged the public hearings. I was pretty much responsible for the public hearings.

Q. All of these things went into the report, the report you drafted; is that correct?

A. Can I explain --

Q. Just answer the question.

A. The hearings were a rehash of the interviews.

Q. I am asking whether all these things were components that were considered in writing the report.

A. Yes.

Q. Are you taking courses at Columbia University?

A. Yes, I am.

Q. Is one of your professors in the courtroom today?

A. Yes, he is.

Q. Can you point him out and identify him by name?

A. Mr. Melzner at the plaintiff's counsel table.

MR. DUNN: Thank you.

THE COURT: All right.

(Witness excused.)

* * *

S. SEYMOUR JOSEPH, called as a witness by defendant, being first duly sworn, testified as follows:

DIRECT EXAMINATION

BY MR. DUNN:

Q Are you a physician duly licensed to practice within the State of New York?

A I am.

Q By whom are you presently employed?

A At the present time I am employed by the New York State Drug Abuse Control Commission.

Q Is that also known as DACC?

A Yes, it is.

Q In what capacity are you employed?

A I am the Deputy Commissioner in charge of the Office of Methadone and Pharmaceutical Control.

Q How long --

THE COURT: Let me get that.

Deputy Commissioner in charge of what?

THE WITNESS: The Office of Methadone and Pharmaceutical Control.

Q How long have you been employed in that capacity,

Doctor?

A I have been head of that particular office for approximately a two-year period of time.

Q When were you appointed?

A I was appointed to other capacities in the Drug Abuse Control Commission as far back as 1967.

During the course of my presence in the Commission, I held several other positions and then approximately two, two and a half years ago, was appointed as head of my present office.

Q Your present position, what are your duties?

A At the present time I have the overall responsibility for three sectors of the Commission's operations.

The first area of responsibility would include the supervision of the programmatic review teams that are engaged in reviewing the implementation of methadone treatment programs in the New York State area.

The second area concerns the operation of the Drug Abuse Control Commission central pharmacy that produces quantity doses of methadone for the Commission's own treatment programs and also produces under contract for voluntary agencies such as the Beth Israel Complex.

The third area in which I am involved concerns the specific supervision of the Commission's own methadone treatment program.

All of these areas from a professional perspective.

Q Can you be a little more specific with respect to your duties in the first category that you mentioned, supervision of programmatic review teams?

What does this mean, Doctor?

A Well, the Commission has appointed as the state authority responsible-- appointed as a state authority by the Federal Government in the latter part of 1972 or beginning of 1973.

In that particular capacity, we had the responsibility for reviewing the kinds of methadone treatment programs that were operating in the State of New York.

To elaborate to a greater extent, we had the mandate to assure that specific kinds of care was made available at specific kinds of physical plants present in order to permit such staff to operate appropriately and in effect, to supervise all professional aspects of programmatic implementation .

Concurrently with that, the DACC was also in the process of formulating its own rules and regulations for the operation of methadone treatment programs that provided for widespread input from the professional community and was finalized in the issuance of a booklet of DACC requirements dated May of 1974.

I believe that was filed with the Secretary of State of New York in the latter part of February 1974.

THE COURT: Let me see if I am clear.

There is an Exhibit 17 in this case which is the copy of the Food and Drug Administration Regulations about methadone programs that appeared in the Federal Register December 15, 1972.

Do I understand that the DACC was put in charge of doing something about these regulations in the State of New York?

THE WITNESS: Tangentially, your Honor. The DACC and specifically my office, is under contract to engage in the programmatic supervision of methadone treatment programs in the State of New York.

BY THE COURT:

Q You are under contract with whom?

A HEW, but over and beyond that federal package, the DACC also has its package of rules and regulations.

Q Before we get to that, I want to be clear.

When you do what you call involve yourself in programmatic supervision, does it have reference to these FDA regulations?

A Yes, it does, your Honor, but the FDA regulations, the original ones that were issued, were developed in great part from the original documents submitted by my office and our present package or the package I alluded to previously, goes beyond the regulations of the FDA.

Q I don't want to get overly technical here, but there has been a question that we were talking about yesterday with another witness and that is, after the Federal Food and Drug Administration came out with its regulations in December 1972, who, if anybody, undertook to see if they were being observed by the methadone clinics in New York City, and it wasn't clear to me, so I am asking you now, was it your agency that did that?

A No, sir, not at that particular time.

At that particular time until July of 1974, that was the total responsibility of the FDA.

As of July of 1974, the contract that I mentioned earlier came into being and that is when the DACC, through my office, undertook the examination and inspection programmatically of programs, methadone programs in the state, in order to determine compliance with the FDA regulations that you have in front of you.

Q And that was the contract with HEW?

A Yes, sir.

THE COURT: I think earlier in your testimony you said that in the latter part of 1972 or the beginning of 1973 you started in doing something?

A If I might, I will try to clarify that.

Originally there was some confusion as to what agency of the State of New York was to be identified as the state authority in New York and that was clarified during the initial portion of 1973 as being the Drug Abuse Control Commission.

There was some doubt whether it was the New York State Health Department or our agency.

BY THE COURT:

Q At that time you were doing it purely as a state function, you weren't delegated it by the federal government, right?

A Yes, sir.

Q That is right?

A Yes, sir, that is right.

Q In the course of that state function, you developed these state regulations which came out in May 1974?

A No, sir. We had been involved in the supervision of our own methadone treatment program since 1969 and we had developed most of the portions of that package as a result of our operational experiences and in effect, as I mentioned earlier, played a substantial role in providing input into the federal sector as well.

So, we have been concerned with these particular areas for a substantial period of time.

THE COURT: All right, Mr. Dunn.

BY MR. DUNN:

Q Is it your office, Dr. Joseph, that makes a recommendation with respect to approval or licensing with respect to methadone programs?

A Yes, it is.

THE COURT: Let me go back a small step.

Does New York State have a system of licensing methadone programs?

THE WITNESS: New York State does have a system of licensing methadone programs and the DACC provides an essential input to the New York State Health Department who has the responsibility for such licensing.

THE COURT: The DACC does not do the licensing?

THE WITNESS: No, sir, not at this point, but the New York State Health Department will not license without the approval of the DACC.

BY MR. DUNN:

Q Does DACC have any function to perform with respect to continuing a license already granted to a methadone program?

A Yes, sir, it does.

Q What function is that, Doctor?

A The DACC has the responsibility for continuing at periodic intervals the examination of the procedures that are taking place in every methadone treatment program.

When I mention periodic, I do not want to imply that this takes place at infrequent intervals.

Where the staff of my office finds numerous deficiencies exist in a program, we make periodic or monthly contacts with such programs to find out whether the program is in compliance with our package of rules and regulations and if not, the reviews would be of a more frequent type.

We kind of operate on a flexible basis, always with the ultimate goal of assisting programs into compliance that are willing to and have the distinct motivation for coming into compliance.

Q How many programs presently operate in New York City, Doctor?

A There are approximately 155, in the neighborhood of that figure.

THE COURT: In New York City?

THE WITNESS: In the Metropolitan area.

Q How large a staff do you have?

A I have three prograammatic auditing teams. Each team consists of a physician and a social worker or anthropologist, and all of my staff --

THE COURT: Each team--

THE WITNESS: Consists of a physician and a social worker or an anthropologist.

The teams are highly sophisticated professionals who have had long experience in line treatment of the narcotic addict and when I say line treatment, I am referring to line chemical maintenance treatment.

THE COURT: I'm sorry, I didn't get that.

Each tem has a physician and each team has a social worker and an anthropologist?

THE WITNESS: And/or anthropologist.

Q These teams are assigned solely to assist with respect to the first of the three categories of duties that you described?

A Yes, sir.

Q What, if anything, occurs, Doctor, when it is found that a program is not in compliance?

A When a program is found not to be in compliance with the regulations, contact is made with the program and the specific areas of deficiency are identified in great detail and usually the --

THE COURT: Could I interrupt one moment?

(Pause)

MR. DUNN: Mr. Reporter, would you read back the witness' answer, please.

(Answer read)

A (continuing) usually the staff of such program is called into a conference at my office and an assessment is made of their willingness to come into compliance and following such contact, a period of time is given prior to an additional inspection or review of the program in question and following that, a determinationis made always within a professional perspective in order to see to it that programs have the appropriate degrees of latitude with which they can treat their patients.

THE COURT: I wish we could just back up a little bit.

I haven't really studied, I am sorry to say, this federal and state regulations. I have to do that and I wish I did it in preparation for your testimony, but I will do the best I can.

THE WITNESS: May I offer a comment, your Honor?

THE COURT: Okay.

THE WITNESS: The DACC package of rules and regulations go beyond those of the FDA.

THE COURT: In what way do they do that?

THE WITNESS: They have more stringent requirements in many portions of the content so that in effect --

THE COURT: In what areas are they more stringent, for instance?

THE WITNESS: In the areas of insisting upon certain kinds of screening and techniques and procedures for screening.

THE COURT: Screening of whom?

THE WITNESS: Of patients.

THE COURT: For admission?

THE WITNESS: For admission to the programs; in areas of requiring specific kinds of medical work-ups.

THE COURT: Medical work-ups?

THE WITNESS: Of the patients.

When a patient is admitted, we require certain procedures to be carried out and protective medical runs of tuberculin testing, serologies to be taken, specific kinds of immunizations to be given to thepatients during that particular time; an assessment of the general physical spelled out in detail and leaving nothing--

THE COURT: Could you explain this?

What were the problems that you were attempting to deal with in developing these regulations? You said that a good deal of the material that ultimately went into the FDA regulations, and of course all the material that went into your own regulations emanated from the work and the observations that you have made over the years.

Can you tell me what problems -- let's just try to get a description of the development of these regulations focusing on what problems you were concerned about.

THE WITNESS: We were concerned during those years, your Honor, with the problems that have surfaced during recent times.

THE COURT: Being what?

THE WITNESS: In effect, we had anticipated the realities that some people were being introduced into methadone treatment programs that were inappropriate for such programs.

THE COURT: Like what kind of people?

THE WITNESS: People who manifestly have given evidence that they were presenting complicated forms of behvaior while being treated with methadone and, in effect, were doing a disservice to the modality.

They should not have been separated from the program in fairly short order.

THE COURT: What kinds of people are you talking about?

THE WITNESS: I am not sure I can target a specific kind of people. The individuals who have become drug addicts, narcotic addicts, if you will, cover a wide spectrum of the population. There is no typical --

THE COURT: I am not asking that.

I am asking if you could somehow describe to me what you mean by the complicated forms of behavior which wouldmake it undesirable to have that person a methadone patient?

THE WITNESS: Individuals would be undesirable for the methadone treatment program if they manifested on a continuous basis or almost continuous basis disruptive behavior, antisocial behavior, certain physical signs of that that were due to the methadone when used in conjunction with other drug abuse.

In effect, any type of patient who did not follow what we would expect to be a regular pathway to a state of rehabilitation.

THE COURT: You say manifestation of the use of methadone and other drugs?

THE WITNESS: Yes.

THE COURT: You are really talking about --

THE WITNESS: Multiple drug abuse.

THE COURT: Can a person be a bona fide patient at a methadone program if he comes to you with a history of multiple drug abuse?

You don't reject those people, do you?

THE WITNESS: It would depend on the nature and degree of his history of multiple drug abuse and it would also depend on numerous behavioral factors that existed in the past.

We have had some individuals who have given histories of multiple drug abuse and have turned out to be excellent patients after they were entered into a methadone treatment program.

That is why earlier I said there is no typical type of addict or picture of a narcotic addict.

He goes into every section of our society from top to bottom.

THE COURT: You are saying that multiple drug abuse is a potential problem that you have to watch out for?

THE WITNESS: Yes.

THE COURT: Exactly what you do depends on various circumstances?

THE WITNESS: Yes.

THE COURT: What were some of the otherproblems you were concerned with in developing these rules and regulations?

THE WITNESS: Since the patient population that had to be served covers such a cross-esection of the population, there were individuals present in it who had different needs, both of a psychological or that of a behavioral nature and certain resources had to be present in each and every program to address those needs.

THE COURT: What kind of needs are you talking about?

THE WITNESS: They too would range over a wide area. Some individuals required counseling services-- I might say that some individuals didn't require anything more than the intake of the methadone. Some individuals required counseling services. Some individuals required vocational services, others required psychiatric services, medical care, surgical care, and the involvement in family therapy.

They run across the gamut of all kinds of the psychological availability of resources, psychological and psychiatric.

THE COURT: Any other problems you were concerned about?

THE WITNESS: We would find individuals who were acting out in antisocial fashion who seemed to lose controls when they were on a preparation such as methadone and of course these people didnot belong in a methadone program.

THE COURT: You say some individual would lose control?

THE WITNESS: Lose the capacity to bring their behavior under certain kinds of control.

THE COURT: Are you saying as a result of the methadone?

THE WITNESS: At times it could have been as a result of the methadone.

Again, what we are talking about is that the patient, the narcotic patient, is a representative of a cross-section of the general population.They are people in the general population. If you hand them a narcotic, they are going to kind of lose the ability to control certain kinds of adversity.

Again, it is similar to the general population.

THE COURT: I thought we had reams of testimony here to the effect that methadone in and of itself has no effect on people,does not cause hallucinations, it does not cause drowsiness or euphoria.

It is just like taking cough drops.

That is what I want to get out.

Does it in some cases have adverse effects on people?

THE WITNESS: Yes, sir. In some cases it has adverse effects on people but those people should not be in methadone programs.

THE COURT: What kind of adverse effects can it have?

THE WITNES: Of a behavioral nature, of a nature that would suggest to the individual that he proceed to multiple drug utilization.

I think I might place the matter in proper perspective, your Honor, by giving you a history of my employment.

When I was first appointed to this position, there was a hue and cry from the pro-methadone, the methadone advocates. They were reluctant to see me appointed to my capacity because they allegedly stated that I was anti-methadone, and nothing could be further from the truth.

I am not anti-methadone. The methadone modality has proved to be a panacea for those individuals for whom it is appropriate.

The only time people have gotten into trouble with the methadone modality is when they have tried to use it as a magic pill to serve everybody and anybody and that is what we are reaping at the present time; butfor the person for whom methadone is appropriate, there cannot be any argument with it if one thinks of it in terms of a rehabilitative medication that is used or has to be used in some instances.

One cannot approach, in my opinion, this matter with tunnel vision. The reality is that for them, for the people for whom it has been effective, it has been startlingly effective.

The unfortunate part of it, if one would identify it as being unfortunate, is that for the people for whom it has been effective,that category of individual becomes non-visible. You don't hear about them. We have people in methadone treatment programs who are performing any and every type of service in this city and state, ranging from being outstanding members of the professions to laborers, going through the gamut of electricians-- you name it. They are there, but obviously when a person who has been in the anti-social sector of our community starts into a program of this kind, becomes socially acceptable, becomes able to interact appropriately with his family, he does not want to have anything to do with being identified as a methadone participant.

Let me give you an example if I can that may illustrate the point to a greater degree.

I mentioned earlier that part of the responsibilities of my office include the supervision of our own DACC methadone treatment program.

Now I am sure, too, your Honor, you are familiar withthe hue and cry that went up when we had a procedure in 1966 and 1967, such as civil certification where people's liberties were being deprived, it was felt in certain quarters,on the basis of judicial certification to the NACC, now known as DACC; well, we have had people participating in our methadone treatment program who were judicially certified to the Commission, who after numerous years, have had their-- the periods of their judicial certification expire and we have over half of our present population in our own treatment program participating on a voluntary basis with the very agency to which they were judicially assigned.

Really, at one time, I think that would have been considered an astounding situation.

Is that because these people also are doing magnificantly in the work force across the entire gamut? Most of the people with whom they work do not know theyare participating in methadone treatment programs. They have no awareness of it, just as I am sure in this particular situation, there are many people in the agencies that are involved in this suit that too have numerous participants in methadone treatment programs, but they are non-visible, nobody knows about them, they are there.

THE COURT: You are raising a lot of points I would like to pursue.

Let me take them one by one.

Can you tell me what kind of person it is, and what is the cause of methadone not being appropriate?

You have to speak as if you are speaking to a thirteen-year old. You have a lot of information based on years and years of experience. This is new to me, although we have had a lot of evidence, but much of this I still have difficulty getting the first time.

What kind of a person is it for whom methadone is not appropriate? How does that manifest itself?

Can you answer that?

THE WITNESS: Well, there are so many individuals for whom methadone is inappropriate, your Honor, that I would have to say any pathological manifestation of behavior, both on the part of the individual or on the part of that individual with his environment would be inappropriate for methadone if such behavior continued on a repetitive basis.

THE COURT: That is a generalization which I understand to some extent, but can you give instances?

I assume that anybody coming into a methadone program who has been addicted for a number of years, he is going to be in a pretty bad way, right? His behavior is going to be something that we call subnormal, right?

THE WITNESS: Right, sir.

THE COURT: So what particular kind of heroin addict or person is it that you feel does not get along well under methadone?

THE WITNESS: Let me try to clarify it and please interrupt me if I go off the line.

If an indivdiual, a narcotics addict, is introduced to a methadone treatment program, and I would like to further specify, a methadone maintenance treatment program, then if the individual continues on a repetitive basis to exhibit antisocial behavior that gets him into trouble with the law, continues to steal things or continues to be unproductive, continues to engage in multiple drug abuse, is found loitering around areas, and in effect, continues the alienation of himself with his family, that person, if a repetitive evaluation is made, is out of order for a methadone treatment program.

Now, there are categories, too, and we are dealing with a behavioral science. There are categories of individuals who may be unproductive because they really don't know how to be productive,so you have to realize that one, in order to be effectively in a rehabilitative category, must assist that person into areas of productivity or socialility.

It is difficult to concretize this area but for me the unfortunate part about this situation has been that we have had a category of professional whom I would call methadone proponents, who to me, have done somewhat of a disservice, because methadone is not a panacea, it is not for everybody, but it is the most valuable type of medication for those for whom it is appropriate.

THE COURT: I was under the impression that a program like the ARTC program would accept heroin addicts that were in a very,very bad way and they would work with them even though they did loiter and were unproductive because they would be a lot worse off if they were not getting the methadone treatment, so it puzzles me if you say that the people just should be discharged from the program if they are unproductive, if they don't establish a family relationship.

That doesn't seem to jibe with what I have hard about the programs.

THE WITNESS: Well, I consider that an individual patient is productive, your Honor, if he is engaged in appropriate kinds of counseling, whether it be of a behavioral nature or social nature, but people being given methadone on the basis of permitting them to continue the multiple drug abuse or behavior, to me, is unjustifiable inthat they are not evidencing any movement towards the legitimate goals and any patient who enters any program regardless of what it is, has to have certain goals established for that patient and the staff has to devote all their energies in enabling thatpatient to obtain those goals.

Now, the goals may very. There may be long range goals, intermediate goals, short term goals, but to suggest that a patient should be accepted or continued in the methadone treatment program who loiters around, who is not participating in rehabilitative components, to me is totally unsuccessful as a rehabilitation.

THE COURT: Is there any evidence you know of that methadone in and of itself can have an undesirable physical effect upon the person taking it? I am not talking about trivial effects like a little sweating or something like that.

THE WITNESS: No, sir. The individuals who take methadone,and again, I hesitate, because I find it difficult to talk about a preparation of this kind without making certain qualifications, or a preparation of any kind, aspirin, any type. I don't want to categorize it and make you think I have these reservations of methadone because it happens to be a synthetic narcotic.

No, I would have those reservations about any type of pharmaceutical preparation.

A person who takes methadone and abuses methadone, well, that individual is an inappropriate person for continuation in a methadone treatment program.

THE COURT: What do you mean by abusing methadone?

THE WITNESS: Who continues to seek additional supplies of methadone to the degree that they produce the ultimate effect for many of losing contact with reality.

THE COURT: Can you put it a little less technically?

In other words, he gets enough of this drug, a big-enough dosage, so he gets--

THE WITNESS: He is bombed out, in the vernacular. He does not want anything or any desire nor is he getting any reactions to external stimuli. He is cold, he is out, he is unconscious in many instances.

THE COURT: Is this the same effect you could get from heroin?

THE WITNESS: Yes, sir.

THE COURT: Can you get this effect by taking it, by taking enough methadone orally or is it taken by injection?

THE WITNESS: Yes, sir.

THE COURT: In other words, you could take enough methadone so you get whatever narcotic effect people seek who want to take narcotics, is that right?

THE WITNESS: Yes, sir.

THE COURT: The terms we have heard in the case so far, and this is the first we have heard of being bombed out, we have heard euphoria, drowsiness. Those have been used as describing narcotic effects of heroin.

Are those the narcotic effects of heroin?

THE WITNESS: Yes.

I am going one step beyond the euphoria, when the individual is in a state where he is unable to appreciate any stimuli coming in from the outside.

THE COURT: Short of that, can he take methadone orally and just take enough to get into a drowsy, euphoric state?

THE WITNESS: Yes, sir, he can.

THE COURT: Depending on the individual, depending on the amount?

THE WITNESS: Yes, sir.

BY THE COURT:

Q I take it the clinic has to regulate the amount of dosage given to the patient to avoid this, isn't that right?

A Yes, sir. Many of the patients, after a period of time that is appropriate for the modality, want to avoid that themselves. They want to not experience it because although at times they could get a euphoria - then the consequences.

Q The reason I am sitting here skeptically, I don't quite know how to pursue this because we have had so much testimony and I remember pressing it with Dr. Dole, I believe, the question -- can you use orally-taken methadone like you would use heroin to get the same effects and I think in words or substance I asked that,and my impression is, and the record will show it, but my impression is he told me it would be extremely rare.

You wouldhave to take a tremendous quantity of methadone or a tremendous dosage to do that.

If we are talking about something that is just a great rarity, then I have less orry than if we are talking about something that can happen with some frequency.

Do you get my problem?

A Yes, your Honor, but if I may comment, I get the impression that there is an attempt to approach this from a negative perspective, from the idea of thinking that even if what I said was the case, that this automatically would make this a preparation that is totally out of the question.

Q Don't worry about perspective. Just don't worry about that. The fact is, we had a tremendous body of evidence favorable to methadone and so forth and I will make my purpose clear.

We have had evidence that a methadone patient is just as normal as anybody else; that the methadone dosage administered by clinics when people are stabilizied does not produce the drowsiness or euphoric effects; people can function perfectly well, they can drive, they can read, write, think, administer, and so forth.

We have had a great body of that evidence.

The thing is, I want to find out the limitations of that. I want to see if there are indeed facts that exist that have not been made part of this record. I want the whole story. I don't want a part of it, good or bad.

A I am attempting to provide as much information as I can to you, your Honor, but, again, I think that people might hav a tendency to approach this subject in what I would consider an irregular fashion if they talk about the methadone patient.

To me it would suggest that the approach be in terms of the appropriate methadone patient. The patient for whom this is truly a medication.

Q I was coming to that, but let me just start at the end I started at because it is necessary.

I would like you to comment as best you can on what it takes to abuse methadone. I don't even understand what that is.

Can it be done by a person on the normal dosage that he gets in the clinic, or does he have to have extreme doses, and I don't even know how to ask the questions because I don't know enough about it, but if there is any way you can explain it to me how this happens in particular cases, that would help me.

A A patient can abuse methadone that he gets in a clinic if the other resources thatare supposed to be available in such clinic are not performing their proper function. By that, I mean that in each clinic there is supposed to be the kinds of professionals that I identified earlier and that are contained in our booklet of regulations that can arrive at assessments as to how the patient is getting along in the treatment that is being given to him.

On the basis of assessments of that nature, the patient may be permitted take-home doses of methadone.

If that patient has demonstrated legitimate responsibility,that he is appropriate for take-home medication, then that patient will not get into any difficulties but will be able to go on.

However, if the patient has been evaluated improperly and not obtained a legitimate level of responsibility before being given this take-home medication, then he may very well get outside of the clinic's door and ingest the take-home medication for the next day.

So, in effect, and that calls attention back to the package of rules and regulations. It requires specific kinds of reviews, determinations of a professional nature in order to be able to develop a reasonable opinion based on behavioral functioning as to where the patient is at any given point in time.

Q Let's say a person were on a dose of 80 milligrams a day. That is a possible dose, right?

A Yes, sir.

Q And let's say that the clinic felt that he had been stabilized on that dose, he had been taking it for a number of weeks or months--

A Yes,sir.

Q Then they evaluate him and say he only has to come to the clinic a couple of times a week and he can take home the doses for the other five days, right?

A There are specific regulations that address the frequency of clinic attendance. For example, in our package of regulations for the first three months, the individuals are required to report at a particular kind of frequency and the federal regulations indicate that there will be no less than two contacts per week for a very extended period of time.

Q It would be possible for someone to be stabilized on a dose of 80 milligrams a day and be given the dose at the clinic and another 80 milligrams to take with him, and he is supposed to take that the next day and not right now?

A Yes, sir.

Q Let's suppose he walks out of the clinic and takes the other milligrams immediately. Is that enough to, or could that be enough to produce euphoria, drowsiness in these problems we have talked about?

A It might be enough, your Honor, but certainly it would produce some additional drug effect.

Q Even if--

A What ever it is. It would produce some additional drug effect. The reason is it may produce euphoria or may not, methadone patients have an usual ability to withstand a great deal of methadone when they are up at the 80 milligram level so it would produce what he considers a desirable methadone effect.

Q And I guess it would probably be hard to sit here and try to spell out exactly what would be needed in any individual to produce this euphoria or the bombed-out effect; we couldn't really do that, could we?

A Well, there are some drugs that lend themselves to abuse more readily than others and one would have to go through the entire gamut of that, but I think it would be rather frustrating.

Q Just talking about methadone.

A Yes.

Q Is there anything in the fact that somebody is a methadone patient that might lead him more than other people to take other drugs, amphetamines, barbiturates, or what have you?

A For some categories of methadone participants, there would seem to be a tendency to engage in multiple drug abuse, yes, but again, for some categories.

Q Whatkind of people? What is the-- why does not methadone cure them of that? Let me put it that way.

A Methadone is not a preparation that could be used in trying to address the alcohol problem or the amphetamine problem. As a matter of fact, for some patients who want to get different kinds of drug effect after they have the methadone, then they want uppers to go the other way.

Q Say that again.

A They want uppers, amphetamines, and they want preparations that will endeavor to overcome the sedative effects of the methadone.

Q You are saying if somebody has a sedative effect from methadone, then they may want the amphetamines to pep themselves up?

A Yes, to try to utilize them and they do try, but frequently it does not have the effect that is desire.

Q Thepeople who get drowsiness from methadone, is that a stabilized methadone patient?

A You are referring to an individual who takes a take-home bottle and then who drank it outside the clinic; he is not what we would call a well-stabilized patient.

It is difficult to approach this in concrete fashion. The patient who is well-stabilized and who is appropriate for methadone treatment will not drink the bottle of methadone outside the clinic. He takes it home and uses it at home.

Q Let's come to that category. You have said that the appropriate methadone patients can be and are engaged inall forms of employment?

A Yes.

Q What kinds of employment? Can you just run through some of the kinds of employment that methadone patients from your clinic have been successful in?

A I don't know if I can repeat all the kinds of employment there are, your Honor, but I would say it would run across the cross-section of all kinds of employment including individuals who have been engaged in interstate transport, driving interstate trucks.

Q Truck drivers?

A People in the professions.

Q What kinds of professions?

A If I had been aware that the question was going to be asked, I would have brought some detail records.

Attorneys, physicians, architects, sales people, mechanics, laborers. When I say mechanics, electricians. The cross-section right across the gamut.

Q You are talking about people who have been successfully employed in these fields, right?

A Yes. People who have become non-visible and blend in with the total population.

Q Are these rare cases or are there many of them, hundreds or thousands or what?

A There are many, thousands of them, your Honor.

Q Aht are the objective signs that somebody is the appropriate patient and doing well so he could be employed? What are the objective signs that an employer can look at?

A I think what an employer can do, and I mentioned earlier that many of the employers who think they don't have such employees are in my opinion deluding themselves because they have them, but the objective signs that one could look for in a patient who is doing well don't exist. It is the same as when an applicant appears and is the same as every other John Doe who might present himself for a position.

The way the determination can be made is if certain laboratory tests are carried out and those laboratory tests would have to be carried out by sophisticated professionals as well, because on the basis of some of the lack of receptivity in certain quarters, the individuals have unfortunately been obliged at times to approach the matter realistically to secure employment. In effect, the individuals would be just the same as anybody in this courtroom, those who are doing well in a methadone treatment program.

Q Going back to these problems-- going back to these regulations, were you trying to deal with the problems that the controls, I take it, the controls in the dispensing of methadone, the controls in the sense of the urine tests, there are rules and regulations about those subjects?

A Yes. I think the rules and regulations that the Commission developed are the same as any other rules and regulations.

If people were going to obey the law, there probably wouldn't be any need for law at all. Everybody would interact appropriately, but we were concerned with the reality that there are some individuals who tend to abuse programs, abuse people, and abuse even employers, and we try to direct attention there to insure the fact that even people who operated such programs were operating quality programs, at least programs of a minimal level of quality that could provide decent rehabilitative services.

Q Back to your own program: How many patients do you have in the program or programs run by your agency?

A We have approximately 1100 at this point in time, your Honor, a little under 1100.

Q And this program has been in effect how long?

A This program has been in operation since 1969, January of 1969.

Q So that is about six years?

A Yes.

Q Can you give me any idea of the number of patients you have treated in the six years?

A We have treated approximately 3800.

Q I would like to get an idea-- let me put it this way: I am trying to determine if what we call the successful methadone patient, the fellow who comes in, adheres to the program, he takes methadone regularly, he submits towhat other services are needed, he stays out of the other drugs, he does not develop any big drinking problem and he is, as far as this problem is concerned, he is what you would consider employable within his skills.

In other words, he is the successful methadone patient which you have more or less indicated to me in the appropriate category. Right?

A Yes.

Q I would like to get an idea, is the person who has these attributes, is he a very tiny proportion of the 5800? Is he a majority? Can you give me any idea of that?

A He would be in about the 50% category, your Honor, that individual. In other words, about between 49% and

50% of the individuals who had been developed from the general population, have appeared to do pretty well in a methadone maintenance treatment program.

Q The kind that could take the jobs that you have talked about?

A Yes. I am talking about those from an unselected population and if you are interested in why I qualify it that way, let me explain.

Q Please do.

A There are some private programs in the city of New York that have been operating in a fashion wherein they have been accepting people that have been detached from other programs so that would be a selected population, and one would see a lesser amount of those persons succeeding.

My office is paying an increasing amount of attention to those programs and we have been a bit hamstrung during the end of last year by an injunction against our package of regulations but that has been vacated and we are moving forward.

Q In your own program, you would estimage about 49%, 50%?

A Yes.

Q Are you acquainted with the Beth Israel program?

A Yes, sir.

Q Would you feel able to describe for us how well you think the Beth Israel program does as far as your regulations?

A In a general fashion, I would say that the Beth Israel program adheres rather closely to the DACC regulations, but I must admit in reviewing some of their programs, we have identified certain deficiencies and we have informed them on a cooperative basis; they have moved fairly rapidly to come into complete compliance with our package.

Q What kinds of deficiences?

A Possibly more of a technical nature wherein certain kinds of documentation was not available for our reviews but in general, I would say the Beth Israel program has been functioning as an optimal rehabilitative resource and when I say that, I am talking about its offshoots as well.

Q In terms of controlling the distribution of methadone in a right way, in terms of providing vocational services and counseling, have you found any deficiencies there?

A No, sir, except in very isolated circumstances that have been corrected on an immediate basis.

I might say that I mentioned earlier that one of the functions of my office is also to supervise the manufacturing of liquid unit doses of methadone for our own operation and we are under contract with Beth Israel to supply them with our unit doses which is a further safeguard in the operation of such a type of program.

Q How about the Bronx State program?

A The Bronx State program, again, I would say in a general sense, they have been in compliance.

In reviewing some of their operations, we have identified deficiencies. We brought them to their attention and they moved rapidly to come into compliance.

Q How about the City program?

A The same would apply with the City.

Q In other words, you have the same surveillance over the City program as you have over the others?

A Yes. The only programs that we do not have responsiblities for reviewing are our own programs.

The FDA does that directly. We do it unofficially but the FDA looks over our shoulder.

Q What about the Veterans Administration programs?

A We have unofficially reviewed them.

Q How are they doing?

A That, too, we have been able to identify certain matters there but on the basis of our recommendations, one of their resources I know has come into compliance. I don't know about the others. I don't recall.

Q What deficiencies did you find?

A Usually of the initial supervision and documentation of levels of rehabilitation. We expect that there will be a frequent contact with patients in an effort for the professionals to be able to make a reasonable assessment as the patients' status and where we do not find such contact documented, then it is unacceptable to us. That does not mean it does not go on. It may go on but it must be documented for us to know it goes on.

Q Those problems, the lack of documentation of the supervision youfound in these institutions we have talked about, right --

A To a degree and in certain instances.

Q And you have requested that be remedied?

A We have insisted that it be remedied.

Q Is it being remedied?

A Yes. It has already been remedied in the programs that you previously identified, Beth Israel, Bronx State and the City.

Q And the VA, to the best of your knowledge?

A We really don't have any legitimate jurisdiction over the VA. It is my understanding that the FDA does not have durisdiction over it as well, but we do assist them in the review process because of our expertise in this field.

Q Have you enough staff to really monitor those programs?

A Well, let me say this, your Honor. We have recently been devoting a lot of our attention to the private sector and I think for obvious reasons.

With respect to the amount of staff they have, it is not easy to get the kinds of people for such staff.

I mentioned earlier, and I emphasize those qualifications, because there is a dearth of such people available, especially individuals who can interact in a professional fashion well with covering sponsors and accomplish our goals and our goals are not to close down programs,but get them into compliance so they can function as resources.

We have three teams operational who have been able to review large numbers of programs during the course of the past six months, both as representatives of the FDA and also as representatives of our own agency.

Could one use additional staff? If they were available, I guess we could use additional staff, but I think we have enough staff to do the job and we are proceeding to do the job, I think in a way that it should be done.

You may notice that some of my testimony, your Honor, may have been a little different than Dr. Dole's or some of the other individuals involved with testimony in this field and some may have been different with individuals who are in the abstinence field, but that is where we stand approaching this matter in what we feel are realistic terms.

Q I would like togo through this.

I wish you had before you the DACC rules, and what I am interestedin, and I won't keep you much longer, the rules about who gets admitted and who gets kept in a methadone program.

Can you point out to me which rules apply to that, and I will give you this.

A Would you like me to --

Q Let me just point them out.

A The ones that are admitted would come under this verification screening and admission, the ones that are to be admitted to the program.

Q What rules would relate to this question you and I were discussing, namely, whether they are able to be free of the antisocial pathological behavior?

A Criteria --

Q Page 6?

A Yes.

Q So you are talking about ii on pages 6 and 7 and one of those things which would disqualify would be evidence that patient is involvedin various inappropriate behavior.

Do you have any trouble with anu clinics in enforcing that or doyou have any disagreement with clinics about the application of that, of those standards?

A Your Honor, the problem is a behavioral one and if there are any abusers in one particular area, one finds them in other areas as well.

Q What do you mean by that?

A We are dealing with a complex psycho-social phenomenon. An assessment is made of the individual so far as his work, his productivity is concerned, his social activities is concerned, his sexual involvements are concerned, familial involvements,then his physical status.

We are talking about a complex behavioral phenomenon and when somebody engages in inappropriate behavior in one area it usually spills over into adjoining areas so we are able to make an assessment and therein lies the need for professional staff that is also addressed to in this pamphlet that can make the determinations as to whether this person should be continued in the program or should not.

I don't want to indicate that this is an arbitrary type of decision-making process.

If a person-- let me rephrase that.

It is not unusual for a methadone participant to challenge his methadone, to try to shoot heroin after he is stabilized.

That really has little if any importance because the individual finds out that he can't accomplish anything by such challenge.

So that the total assessment is what is important, and I don't want you to think that because one negative determination is made that this fellow is automatically rejected.

He is not.

The matter has to be considered in context and also in relation to a legitimate, the legitimate experiences we have all had with this modality and in people who are not appropriate for this modality, they are screened out quite rapidly in the public and voluntary programs; quite rapidly; where other issues prevail in some instances, there may be some greater degree of retention.

Q What I am wondering, do you have any disagreement with any of the major programs about the application of those rules? In other words, do you have situations where Dr. Primm of ARTC, who feels that a class of people should be kept in the program despite certain behavior, and your people disagree with that.

Do you have any differences, any important differences that you have detected on this subject of admitting patients and retaining patients?

A Well, thus far we have not had any substantial diagreement or as I recall any disagreement with people who are running large programs, and in regard to the people who should be admitted.

Let's concretize as much as we possibly can in this book. In addition, the ones who also should be admitted has also been concretized,specifically to address the areas of your concern.

The possible areas of disagreement that may exist between Dr.Primm and me in certain matters are resolved on the basis of our insistence of complete adherence to this or that could possibly be the case with other programs, but I have not encountered any particular program in interacting with the professionals who have been long involved in these areas such as Dr. Dole, Dr. Trigg, and Dr.Primm on the basis of them recognizing that our concern is professionally oriented and our goal is to rehabilitate as many of these people as possible, recognizing the importance and value of this particular modality, and to me, if one denies it, one is denying daylight during daylight hours.

It is just outlandish.

Q If you deny what?

A The validity and appropriateness of the methadone maintenance treatment modality for the people, for this non-visible group.

I would venture to say people who have been discovered to be in methadone treatment programs probably under other circumstances might not have been discovered and they would have gone on working without having ever come to the attention.

That is the reality to me. That represents in a highly-simplified and oversimplified way the experiences that our agency has had with this very important modality.

I didn't want to make a speech.

BY MR. DUNN.

Q Since the promulgation of the DACC regulations in May of 1974, how many methadone programs in New York City has your staff inspected?

A I believe in the neighborhood of 80 or 90.

Q That would be a little more than half of the existing programs, Doctor?

A Approximately that.

Q Do the programs in New York City operate under what is known as an interim authorization or permanent authorization? Are there two types,or interim approval and final approval? Are these the two types of approval?

A Yes, sir. They have been the two types that have -- been used thus far.

Q What percentage of the programs in New York City operate under interim approval?

A The particular programs at this point in time operating under interim approval, I believe, number about 35 or 40 programs.

Q Is there some reason that these programs have not received final approval?

A Yes, sir.

Q Can you tell me what that is, Doctor?

A Most of the programs that I have identified are in the private sector and the programs have not been in compliance with our package of rules and regulations, and as you recall, I mentioned an injunction that has just recently been vacated that gives us again our rightful authority to move in and assure compliance or else terminate our approval.

THE COURT: Would the injunction prevent you from enforcing your regulations against the private --

A Yes, it prevented us from enforcing our regulations against certain portions of these regulations with which the programs were out of compliance.

Q About when was that injunction in effect?

A Somewhere around January 5th or 6th of 1975, give or take a few days, of this year. It was vacated.

Q When did it go into effect?

A I don't know the date, your Honor.

Q That slowed your efforts down as to the private clinics?

A Yes.

It wasonly after the submission of a few affidavits on my part that the injunction was vacated.

BY MR. DUNN:

Q Did your teams investigate or inspect the ARTC clinics in New York City?

A Yes, sir, we have.

Q What deficiencies, if any, were noted?

A I don't recall. If I had known the questions were going to concern issues of this kind, I think I may have reinforced myself with some appropiate material. I have no idea that they would, but another issue I would like to raise, and I don't know the answer to it only being a psychiatrist, as to just how much information about these programs should or can be given at this point in time in view of the conferences that have been going on between my agency and theirs in the process of assisting programs into compliance.

THE COURT: If you have any problem along that line and you want to consult about that, just say so.

THE WITNESS: Yes.

I think it would be inappropriate of me in view of the fact we have certain programs and material about programs in our counsel's office, and I don't want to jeopardize any procedure, and I am not identifying Dr.Primm as being in that category at all.

Q Of the eighty or ninety programs that you say your staff has thus far inspected, can you tell me what deficiencies you found? What percentage of these programs, what number of these programs have you found deficiences of sufficient gravity to cause you to call in these programs and confer?

A Some of the programs--

Q How many of the programs, Doctor?

A I would say I probably have conferred with about a dozen of them off the top of my head, a dozen programs, but most of them have been in the private sector.

Q Do you have the authority or the power, Doctor, does DACC have the power to revoke the approval granted to a program?

A The DACC has the ability to rescind its approval and indicate that to the New York State Health Department and to the FDA.

On the basis of such removal of approval, the other agencies would automatically revoke the approval as well.

Q Has this occurred in the past, Doctor?

A It has occurred with a few programs, yes, but again--

Q Can you identify the programs whose authorization has been revoked or approval has been revoked as a result of the action taken by your agency?

Can you name one of them?

A Again, if you are talking about a legal action, I cannot cite one of them.

If you are talking about the process of the program withdrawing applications after conference in my office, I can name a few of them.

Q I am talking about a program whose approval, DACC has recommended be withdrawn or revoked and which in fact, as a result of that recommendation, has had its approval revoked by FDA.

Has there been any?

A The State Health Department moved in on a program out in Queens, Dr. Weinbraub's program, and we played a role in the JAn operation.

There are a few others. I really don't have that information at my fingertips.

If I had known you wanted it, I would have reinforced myself but we also, I might add, have conferenced with program sponsors and have had them terminate their operations such as the Hausknecht one up in 190th Street in the Bronx, but I would emphasize that there are several programs that are in our counsel's office,as I mentioned earlier, that are there in order to move forward in compliance activity.

Q If the deficiences noted are of sufficient matter they would result in a program being denied further approval?

A Yes, sir. It would indicate that the particular programs that are in that status are in the status because they do not comply with the minimal requirements of our booklet,Part 2021.

Q Assuming, Doctor, that it is necessary for an employer to rely upon representations made by the program administrators or program personnel with respect to the participation of prospective employees in the program, are there some programs, based on your experience, that you would consider reliable with respect to representations that they would make with respect to their patients?

A Yes, sir, there are some programs I would consider reliable.

Q Are there some you would consider unreliable?

A Yes, sir, there are some I would consider distinctly unreliable.

Q Can you give me the names of the latter group?

THE WINTESS: Again, I am in a dilemma.

MR. DUNN: Your Honor, this is the very thing an employer is confronted with when asking a state authority of the reliable or unreliable programs.

THE COURT: You have never even tried informally?

MR. DUNN: We did try, your Honor, if I may differ.

THE COURT: When?

MR. DUNN: In a conference with Mr. Joseph that Mr. Summers and I had some time ago. We asked the same questions.

THE COURT: After this litigation started?

MR. DUNN: Yes, sir.

THE COURT: He is in almost a judicial capacity.

He has to make determinations. To just informally begin reciting this, this can have an effect on the people conducting these clinics.

I don't know it is informal here but it isn't the result of any specific formal finding.

BY THE COURT:

Q Let me ask you this.

If you are in the position of the Transit Authority and you were interested or you were compelled in some way to consider methadone patients for employment; everybody says they would be interested in getting a reference from the clinic and that is obvious.

A Yes.

Q You would be interested in knowing whether you could rely on the reference by the clinic, right?

A Yes, sir.

Q Let me just backtrack. Yousaid there were some 155 programs in the New York Metropolitan area. Are those 155 different institutions or onwerships -- I am not making this very clear-- or is it 155 programs but many of them are under the same--

A Yes, sir. The latter would be the case. Beth Israel has a rather substantial number under their administrative and programmatic supervision.

Q In other words, one institution might have 30 or 40 clinics or programs?

A Yes.

Q Would you be able to tell us how many different operators or institutions there are in New York City?

A The number of different-- I can have that information for you, your Honor, but most of the programs in New York City are operated by Beth Israel, HSA, the City, and the Bronx Municipal or Dr. Lowinson's program up in the Bronx.

Those are in the public and voluntary areas with the exception of our own program, of course, where we operate approximately ten.

Q In the City?

A Yes, and including Buffalo.

Q But most of them in the City would be operated by Beth Israel or the City or Bronx State.

A And DACC.

Q And then aside from that?

A You have some--

A 39 private and of the 39, some of them are owned by the same sponsor.

Q I don't think we need to get the exact number, but let's assume in the City you have these four large programs and then you have maybe 25, roughly, private programs, or whatever it is; how is an employer going to know who he can rely on for a reference and who could he rely on for valid information or monitoring or whatever he needs to get?

A I think it is an appropriate question, if I may be a little judgmental myself, and I sympathize with the lawyer's problem, but I don't think it is too much of a problem, really, if one realizes that there are resources such as our own agency who can assist the employer into making a determination.

That is No. 1.

No. 2, I think many of the large employers have their own medical departments who have a certain level of expertise in the area and we would be delighted to assist them in any and every way that we possibly can.

THE COURT: How can your office assist an employer?

THE WITNESS: What we can do is indicate those particular programs we feel would be able to provide the employer with reasonable,reliable information that he is seeking.

Q I thought that was the question that Mr. Dunn and Mr. Summers asked you a while ago and you said you were not able to answer?

A It was my interpretation and possibly I was in error, that the question directed itself towards the identification of particular programs.

MR. DUNN: I think that is substantially correct.

Mr. Summers and I had a conference with Mr.Joseph before this case, who we found very helpful, cooperative and extended every courtesy in discussing his office's responsibilities with counsel.

THE COURT: It seems to me--

Q I don't recall how it was phrased before but let's take it as of now.

Would your office be willing to advise the Transit Authority on this question of what programs they could reasonably find reliable in giving them information and references?

Would you be willing to name names in that way?

A I don't know if we can approach this matter so far as in legal terms.

Q I am not asking you to name names right now. I am saying if in the future the Transit Authority was interested in employing methadone patients, could they get from your office information in consultation about who they could rely on in terms of people at these clinics?

A I would be inclined to think that that information could be developed through our office, if it is appropriately legal to do so.

Q You are not sure now?

A We are an active federal agency and to actively approve a clinic, one has to keep in mind there are qualitative differences, too, in any type of clinic's operation and that is what is generating a bit of anxiety in me, that one clinic may be more able to provide the names whereas I might feel more kindly disposed to one clinic than to another.

Is it legally proper for me to take such a position?

Q Let's assume it might not be, that you might not be able to informally and privately give evaluations; what is the Transit Authority going to do, what do they know?

A Let me put it this way: The posture of the office has always been to be as completely cooperative with any and every agency or business as we can be and I think that the statement that was mase previously would tend to validate that as well.

We have tried to assist as much as we possibly can and we shall continue to go on doing just that.

Q I take it you could give out the names of the clinics that were licnese, formally licensed?

A Yes.

Q And you could give out the names of the clinics that were under any kind of formal discipline or disapproval?

A Yes.

Thatwould be a matter of public information.

BY MR. DUNN:

Q Would you be able to venture any opinion with respect to the reliability of the 65 programs that your office has not yet had occasion to inspect?

A I think we certainly could because past contacts with many of those programs. When I say my staff has been engaged in programatic reviews, it is in terms of the indepth programatic reviews such as are needed in compliance with our Part 2021, but we have had substantial contact with many of the others because of the DACC's funding responsibilities.

As you know the DACC is engaged in funding most of the public and voluntary programs in the State of New York and in that fashion we have been able to exert an influencing role in what resources are obliged to be present.

BY THE COURT:

Q Is this the Medicaid funding?

A This is direct funding of the methadone monies that is usual.

That usually consists of what are called last dollars. For example, if a program is funded for $10 million, roughly and it is possible for that program to generate $8 million in Medicaid funds, then the DACC would pick up the other $2 million.

In other words, last dollars to that particular program.

Q Does Beth Israel and City and Bronx State, do they all get some of that money?

A Yes. Each one of them does get methadone maintenance money from the DACC.

Q Do any of the private programs get that money?

A No, sir.

BY MR. DUNN:

Q Are you familiar with the confidentiality regulations, Dr. Joseph?

A Yes, sir.

Q Would you tell me please with respect to the programs that you are responsible for administering, what information you would provide to a prospective employer, assuming the patient consents to the release of the information and requests that you supply the information to the employer? Initially what would you supply to the employer?

A Well, we would supply what we felt was appropriate information to the employer, but let me say before that, the DACC would not even refer any individual for employment whom we feel was not able to undertake any employment.

Q I am quite sure of that but once again I would like to know, if an employer advised DACC that they have a candidate for employment who states he is a participant in one of your programs and this participant as well as the employer seek to have information given to the employer, what is the maximum information you would give an employer?

A Always within the limits of the confidentiality law. We would attempt to cooperate with the employers medical department to the highest possible degree.

Q Would that include permitting the file, the medical file of the individual to be viewed by the medical director of the employer?

A If that is consistent with the confidentiality laws, we would not in any way whatsoever violate the laws but if it were consistent with the laws, we certainly would cooperate in any and every possible way.

Q Do you know whether this is consistent or inconsistent with the regulations?

A I am not fully versed on the interpretation of it. I know there are some limitations. That is why I have qualified my remarks.

Q What information would you provide on an ongoing basis to the employer assuming continued consent of the patient and the continued request of the employer?

A I think one of the responsibilities of any treatment program is to insure that the patient who is being served is of a nature that would not disrupt any relationships with the employer at all.

Q I am sorry, would you repeat that.

A I think one of the responsibilities of any treatment program is to insure that proper relations are maintained with the employer in an effort to provide the employer with whatever assistance can be provided.

I think if there is any indication that the patient is evidencing any signs of relapse, why there would be some communication between the program -- should be between the program and the medical department of the employer. However, I think that that is kind of putting the cart before the horse. I think that long before there might be an awareness on the part of the employer himself, maybe the medical department of the employer that such is the case, but here again we are approaching the matter from a negative perspective, and I certainly think that one should take all aspects of this into account, but many of these individuals who are appropriately referred for employment will continue on and it would be the program itself who would be first aware that something irregular might be taking place and in effect introduce whatever other types of strategies or other types of treatment inputs are necessary; but the relationship between a program and an employer is a pretty important one to me and I think that the relationship can be a very good one and can also assist the employer not only with providing important resources for this category of patient, but also providing important resources for the rest of his employee staff, for the rest of the professionals on site.

We have been talking about specific people as being in methadone maintenance treatment programs, but any large employee group in this city or state, most large urban areas has loads of problems with drug abusers of one kind or another and by gosh, it strikes me that to be able to have ready access to increased expertise inthese areas should be the desire of every employer. I would think. Maybe my remarks are gratuitous but I would think that such should be the case. We would do everything possible. We think it is a sad commentary on our present society to exclude individuals who are the same as everybody else. Do we exclude people taking digitalis?

Do we exclude people taking anti-rheumatic medication? Do we exclude people who are taking quinidine? Why exclude people who are taking other medication -- please forgive me from being carried away.

THE COURT: Anything else?

Q I assume that you would give the employer no information if the consent of the patient has not been given or withdrawn.

A Again, what can be given would be given. We have always endeavored to cooperate.

Q I am saying if the consent of the patient is not given to you or if the patient withdraws his consent to furnish medical information to an employer, I assume then you would give no information.

A That is true, sir, but we wouldn't refer a patient to an employer who would not give consent for exchange of information with the medical department.

MR. DUNN: Thank you.

BY THE COURT:

Q There may be in the record a conflict in the evidence along this line and you might be able to help us out.

I think there has been reference to a study by a Dr. Taylor in Philadelphia about continued drug abuse by methadone patients after certain periods.

Are you familiar with that?

A Yes, sir.

Q I think Dr. Rosen that you will find Phoenix House testified, or one of the witnesses recently testified that he felt that there was a very high percentage of substantial drug abuse by methadone patients going on even after a year. I am not talking about -- he was not talking about trivial, he was talking about substantial drug abuse.

Other witnesses have testified that the amount of any substantial drug abuse, at least after a year is very small, minimal.

Are you able to comment on the Taylor study? Are youable to commont on the general question of how much drug abuse exists among the methadone patients? It is of interest to me to know whether substantial drug abuse, continued drug abuse relates to 90 percent or something much less. It is of interest.

A With respect to the study by Taylor, what he was alluding to, as I recall, is the fact that methadone patients chip. The occasionally try to shoot heroin to see if it has any effect.

Now, even good patients who are appropriate for the methadone modality may chip before they have really gotten out of the total addiction environment. That is really of little importance.

Q Why is it of little importance?

A Because the individual can go on and interact appropriately with the environment and on the basis of our past experiences, these fellows try it once or twice then forget it. They don't want any part of it because in effect, they have wasted their money. They haven't had any drug effect such as they had earlier, so in effect, it is of no particular importance to them.

Q Is that what the Taylor study relates to?

A As I recall it. I may be confusing the study. Was that the one done in conjunction with Carl Chambers?

Q Yes.

BY MR. DUNN:

Q The Chambers & Taylor study in 1970 compared a cohort group of methadone patients who had been in treatment at least 24 months. The finding was that during a one-month period, 97.6 percent of the cohort study used an il licit drug at least once during that one-month period. That included, as distinguishable from some of the other studies, it includes amphetamines.

A Yes.

THE COURT: This was people who had been on for 24 months?

MR. DUNN: Yes.

THE COURT: And 97 percent used some illicit drug?

MR. DUNN: 97.6 percent used some illicit drug once during this period.

BY THE COURT:

Q That is a high percentage. What do you say about that?

A I remember that during the course of that particular study, they did not have the kinds of structures such as are required in the State of New York. As I recall, it was continued as a type of medical out-patient study which would have no similarity to what we have.

Q You mean as far as the type of program?

A Yes. The one has to be concerned with the intricacies and the intimate portions of programatic fielding, what is present, what can be brought to bear. If people are just given their methadone, sent back into the community without any assistance in addressing some of their other psychosocial needs, that is one thing.

What we are talking about here in the State of

New York is the presence of resources in order to hopefully address all needs if the patients require it.

So, the pertinence of the study, what we are actively involved in here in New York is somewhat questionable.

Q Aside from the Taylor study, can you comment, give us any information on what you think the percentage or indicents of drug abuse is in methadone patients, and I am talking about not just the chipping, but the use of amphetamines, barbiturates.

A It is substantial your Honor, and again, we are talking about two different categories of patients. That is what disturbs me in not being able to communicate where I come from. We are talking about two entirely distinct categories of patients like Dr. Rosenthaul comes in here and says well, a lot of people engage in multiple drug use or abuse who are on methadone programs and I can't dispute that at all. A lot of them do, but those are the patients who should be in the methadone programs to begin with.

I am making the statement here. I presented a paper in the Westchester County Mental Health Society more than two years ago and at that time I said that 50 percent of the people in methadone treatment programs shouldn't be participating in methadone treatment programs. Okay. That is a reality.

Q When did you give that paper?

A I think it is about two years ago, your Honor.

Q Go ahead.

A The reality is that these particular figures would seem to replicate my statement earlier about the 50 percent or 49 percent of the patient population has been able to do quite well on the modality , so the unfortunate part of all of this is that it is my feeling that we are not directing the attention, I hope I am wrong, to the people who are doing well in the methadone treatment programs for whom it is appropriate, for whom it has been a rehabilitative resource, a good one, a great one, with the people I thought you were concerned with and not that the people who shouldn't be in the methadone programs have unfortunately still be continued in them and one cam make reasonable determinations on the basis of that segment.

Q Wait a minute.

Do you still believe that in New York City, about 50 percent of thepeople in the program should be in?

A I would say at the present time in New York

City, a substantial number of the people in the programs doesn't belong in those programs and my office has directed its energies toward any procedure to separate the people from them or to undergo the legal processes for revocation.

Q Your office is directing attention to what?

A Is directing attention towards the procedures that are necessary legally to follow through to revocation of the licensing of those resources that are providing treatment to people who are inappropriate for this modality.

Q The importance of that for my case, is that this class action is brought on behalf of all methadone patients and the question is, the constitutional right of all methadone patients who get considered for employment. I don't have to hold that each and every one is a constitutional right. That is not the point but I have to be concerned in some way with all of the methadone patients and to hear that a large percent shouldn't really be in the program because of these problems presents a problem in this case.

Even recommending that 50 percent or whatever it is is perfectly okay.

They are not labeled, they don't go around with badges.

MR. DUNN: May I just correct the definition of the class. The way we define the class is as persons who are denied employment solely because of their participation in methadone programs. We certainly never have brought this as an action on behalf of -- we have never alleged that the mere fact of participation in a program in and of itself should make a person eligible. What we are saying is, the mere fact of participating should not disqualify and the essential part of our case and what we have tried to demonstrate by testimony is exactly what Dr. Joseph is getting at, that distinctions can be made within the methadone maintained persons. I don't think it is fair to categorize our category --

THE COURT: I don't understand the class to be defines as being anything less than all methadone patients, present and past.

Of course you get involved in differentiations of individual cases and that is what the case is also about but again, the people don't go around wearing badges and we have apparently, according to you, half of this class shouldn't even be methadone patients. They are not good enough to be methadone patients, right?

THE WITNESS: I wouldn't say they are not good enough to be methadone patients, but they exhibit certain kinds of systemology that indicate that an alternative method of treatment would be more advisable.

Q And is the percentage still around 50?

A. Again, that would depend on the particular clinic. If we were to go to Beth Israel, we would find that it isn't about that amount.

Q What would you say about Beth Israel?

A. I would be inclined to think that their rate would probably be in the 80 to 85 percent figure.

Q That are appropriate patients in your view?

A. Right. I kind of qualify on the other 15 percent because there are certain patients who have to have time, have to be functioning for a while so that a legitimate assessment might be made of them, whether they in effect should be continued on a methadone treatment program, or whether they in fact are inappropriate for it.

Q I guess what it boils down to, you recognize that in the -- considering all the clinics as a whole, you have some substantial percentage that you say, in your judgment, shouldn't be in the program, right?

A. Yes, sir.

Q And taking the programs as a whole, is that as much as 40 or 50 percent?

A. So far as the total figure is concerned, the individuals who have been discharged from places like Beth Israel would occasionally gravitate to the resources and would have lesser requirements, so that the total numbers would probably remain somewhat stable, depending on where they were located.

Q. I guess, without laboring this any more, it boils down, if you are an employer and you are interested in employing a methadone patient, you simply have to have some way to discriminate between the appropriate and the inappropriate, right?

A. Yes, sir.

Q. and we have covered that as well as we can.

THE COURT: Do you have anything else?

MR. DUNN: I have completed with the witness.

MR. BALBER: I would like some cross, your Honor.

THE COURT: We will take a short recess.

(Recess.)

CROSS EXAMINATION

BY MR. BALBER:

Q. Dr. Joseph, during the last part of your direct examination, you estimated that in your opinion roughly 85 percent of the persons in the Beth Israel program were appropriately, as you called it, in that program. In your opinion, is that same percentage -- I realize the percentage is an estimation, but is that percentage roughly applicable to the city program and to the Bronx State program as well?

A. Yes, plus or minue.

Q. To public and voluntary programs as you call them generally?

A. Yes, sir, I would say that.

Q. Then the 50 percent figure applies primarily to someprivate clinics, is that correct?

A. And could even exceed thatin terms of the private clinics as well.

THE COURT: How much of your own clinic?

THE WITNESS: I categorize ours at about the 50 percent level originally on an overall basis, but right now, with respect to the numbers we have, ours range in the same category of about 80 percent, 80 to 85 percent.

Q. By the way, are there some private programs that are in compliance with your regulations?

A. Yes, sir, there are.

Q. And they have achieved final approval as opposed to interim approval?

A. Yes.

Q. Dr. Joseph, a central problem that has concerned the partisans and the Court in this case is justhow an employer goes about screening prospective employees when the employer has been notified that the person is in a methadone program, either through a urinalysis or because the applicant tells the employer. You have had a lot of experience in this field. Can you give us a general description of just the procedures which, in your professional estimation, would be necessary for an employer to bring to play to reliably screen methadone participants applying to that employer for a job?

MR. DUNN: I object on the grounds that the witness has not demonstrated his expertise in this area, your Honor.

THE COURT: Overruled.

A. It would be necessary for the employer to be able to secure information as to the functioning level of any particular applicant, in effect by communication, hopefully with a treatment program, with someone who can provide that information.

I would think, too, that it would be of extreme important for the employer to realize that maybe he is unable to engage in a legitimate procedure, but would have to call upon thexpertise of a physician to engage in these interactions.

THE COURT: I don't understand that. Extreme importance to do what?

THE WITNESS: To have someone with some level of understanding of the medical or psychosocial problems that are involved in this particular area in order to develop the kinds of information that would be useful for such employer.

Q You are talking about an outside specialist or consultant; is that correct?

A. Well, I think of an employer, and if I might just speculate for a moment, and I don't know if I may --

Q We will see how far it goes.

A. If an employer were to have a medical department whose medical director could communicate with an individual who has the expertise in the field, and develop information as to the readiness of any particular applicant, I think that would be highly desirable.

I think it would be not only highly desirable on the part of the applicant, but I think it would be doubly desirable on the part of the employer by not excluding the very valuable employees from his potential work force.

I think, too, that there are agencies either existent or that can be developed or relationships that could expedite the procedures in order to effect employment of this type of applicant.

Q When you spoke of outside specialists, you are referring to persons like Dr. Harold Trigg?

A. Yes, sir, I think Dr. Trigg is as qualified as anybody in the field, and certainly more qualified than most, and could be of tremendous assistance in this area.

Q. Assuming, of course, that the employer had a medical department with full physicians, do you represent that an outside representative is a necessity before any methadone patients could be employed by an employer with some reasonable expectations that those persons would be reliable employees?

A. I am not trying to imply that it is essential to have an outside consultant. I think where medical staffs exist, that it would be desirable, possibly in order to enable the program, in order to have even the employer understand that the patient is involved, and to see if there are any modifications in his activity in either direction, so that there can be cross-communication.

But, you know, any individual who is participating, appropriately, I over-use the phrase and forgive me for it, in a methadone treatment program, you know, is non-visible. Most of the times this fellow or gal can proceed to function just the same as anybody or any other employee in the organization. There is no need for it. If the proper relationship has been developed, assuming that there is need for one, with the treatment agency, then the treatment agency is more concerned that the fellow do as well as he possibly can than anybody else. That is what we are all about really, you know.

Q. I guess the central problem we are concerned with is how easily can you identify who is appropriately participating. For example, you said multi-drug abuse was a problem among those persons who were inappropriately in methadone programs. How easy is it to screen out the multi-drug abuser?

A. On the basis of referrals from a type of program with whom the employer may have some close relationships after a period of time, it becomes evident that no referral will be made until the patient is ready to initiate work, until the patient is able to carry out whatever his responsibilities may be there.

I have made the statement before, and let me reiterate it for emphasis, that there are so many people on methadone programs who are working in the present work forces of most large companies without them being aware of it, because they don't evidence any unusual or pathological symptomatology.

THE COURT: I suppose we have all done a lot of thinking about this. I suppose you try to find out the same information about the methadone patient applicant as you would find out about another applicant. You would ask about if he had a job now that he was trying to come from. Youget references from that job, jobs before that, find out if he is married, divorced, criminal record. You would look at the man, give him some tests.

I don't know what they do now, but you do the same thing in a way, wouldn't you?

THE WITNESS: Absolutely. There should not be any difference.

THE COURT: And you obviously would be interested in all references,and one of the references you would be interested in is from the clinic, right?

THE WITNESS: of course.

THE COURT: I don't think -- you are trying to get a list of all the criteria.

MR. BALBER: I don't want to belabor the point.

THE WITNESS: I would say, as the Judge has said it far better than I can, the things that one would expect to be present in any employee would be looked for in the applicant at hand.

Q. Very briefly, it is easy to screen out the multi-drug abuser. Does the same thing apply to the methadone abuser, the acting out person?

A. Yes.

THE COURT: How do you do that? How do you know whether the guy is doubling his dosage of methadone to get narcotic effect?

THE WITNESS: Well, he comes in and has a repeated story of having had his methadone stolen. It's a repetitive type of situation. Or else he may come in and evidences signs that he has gone beyond the dose to which he has been stabilized.

So that the clinical symptomatology that presents makes it not a difficult task to determine whether or not the individual has abused his methadone intake.

Q. Dr. Joseph, you stated earlier that some persons come into a program and they start taking the methadone and at that point they begin to evidence anti-social behavior, acting out, disruptive behavior, that sort of thing.

Did you mean by that testimony, and I would like you to explain my misunderstanding, that the methadone itself induces this antisocial behavior?

A. No, sir. Let me clarify what I meant by that statement.

Methadone itself certainly will not produce any such effect of that kind in an individual. Heroin itself will not produce such an effect in an individual as well. What I meant to point out is that there are psychological categories, the pre-psychotic individual who is hanging on by a fine thread in behing able to mobilize the controls overhis behavior --

Q. Is that the kind of person we commonly say is approaching a mental breakdown?

A. He might be. He is a pre-psychotic individual hanging on by a thread, as I mentioned, and any type of narcotic substance at times could make him dissociate; but it's not the methadone that is doing it in that instance, it's the underlying basic psychopathology of that individual; and here too he would be an inappropriate individual for further methadone maintenance care.

Q. How soon after admission to a program would this underlying psychopathology become evident?

A. It could be evident before admission to the program, and hopefully that individual would be screened out. It is for that reason that we need the various professional resources available.

In our own operational treatment program, we have psychiatric evaluations of all patients, and usually, if we find a schizophrenic, which I was describing, he would in effect be screened out.

Q Dr. Joseph, the Court has a copy of your DACC regulation booklet, so I won't go into it in great detail, but I want to bring out a few things. That booklet prescribes minimum patient-counselor ratios, does it not?

A. Yes, sir.

Q. What is that ratio?

A. It's one to fifty patients.

Q. One counselor --

A. One counselor per every fifty patients.

Q. Does this mean that the counselor is intended to divide his time equally among all the patients?

A. No, not at all. As a matter of fact, the ratios were carefully figured out with the realization that possibly a third of the individuals or even forty percent of the individuals would require minimal counseling care; but also with the recognition that there was a category of patients at the other end of the scale who would require intensive counseling activities.

So that the ratios were figured out taking into account the realities of operational problems and treatment of this category of patient.

Q. This means the counselor is only working intensively with about thirty petients or so?

A. Yes, sir.

Q. In addition to counseling, can you describe just generally the other kinds of supportive services that your regulations encompass?

A. Well, the regulations address thesmelves to the reality of every sponsor providing the physical plant that can house professionals and permit them space in which they can engage in their various occupational pursuits. There is to be a medical section where the nurses can be present in order to assess the medical status of the patients as the come in for their methadone. There are to be physicians available who are present for referrals from the nurse or for periodic reviews of themedical status of the patients. There are counselors available to provide counseling activities of varying degrees from superficial levels down to possibly more in depth types of handling. Vocational counselors present who can provide their particular levels of expertise in an effort to engage in job development activities as well as the counselors with the patients.

Over and beyond that, there have to be the availability of comprehensive resources that can be brought to bear by the referral of these patients to those resources should the need for further, more highly specialized care be indicated, such as psychiatric services, family planning services, the entire gamut of rehabilitative services that we can think about.

It doesn't mean that every patient is to be subjected to all of these, not by a long shot.

Q. Why is that?

A. The reason for that is because there are some patients who have been involved in narcotic addiction and who are presently in methadone treatmentprograms who require a minimum of psychiatric services or a minimum of other kinds of rehabilitative services.

With the medication, this percentage is able to go on and function socially, productively in society. Some require one or more of the services. Some require all of the services. Some require the services that have to be supplemented from the surrounding community.

Q. What proportion require the minimum level that you mentioned?

A. Usually I would say that in the neighborhood of the upper third, you know, would include many of the patients who require a minimum amount of services, but remember, we are talking now about a methadone treatment program that treats an unselected population.

I qualify it in that way because some of the programs in the private sector are treating a selected population of people who have been detached from other treatment programs.

Remember, when we approach this, we hace to take all of these factors into account in order to enable us to assess the matter in proper terms, I feel.

Q. But what you are saying is true about Beth Israel, Bronx State, City Methadone, some private programs?

A. Yes, sir.

THE COURT: You mean the statistic?

MR. BALBER: The one third.

THE COURT: Ye said the upper third includes people who required minimal treatment.

Q. Did you mean to say include or consists of?

A. I meant to say includes. I think the number contained therein would vary according to the patient population.

Q. According to the patient population?

A. Right.

Q Getting to what programs have patient populations that would have the highest number of the one third?

A. Beth Israel. They have moved along to categorize patients so that they have their phase three clinics and the people are readily identifiable there as having attained a level of rehabilitation and are able to -- there too you would see in one of their phase three clinics possibly 100 percent of the people who have in effect made it.

But my original remarks were directed to an unselected population, not to the phase three clinics who would probably consist 95 to 100 percent of people doing quite well.

THE COURT: I wish we didn't have to keep you any longer. Do we have evidence about Beth Israel's organization?

MR. BALBER: Phase three?

THE COURT: Yes.

Can you describe that briefly? How do they organize?

THE WITNESS: What they do is, after a period of time, if individuals are found to need a minimal amount of services and are doing quite well, they are considered as phase three patients who require this differential in service, and well they do, the people who are making it quite well on the outside in all the behavioral areas that I previously identified, so that in effect that too is a selected population, but it's selected in the reverse as compared --

THE COURT: Do they have separate phase one and phase two clinits?

THE WITNESS: Usually the phase one and phase two are combined.

THE COURT: But they have their patients organized. Ifyou go to Beth Israel, you are included in something called phise one or phase two or phase three, right?

THE WITNESS: Yes, sir.

THE COURT: And that has to do with the progress you are making?

THE WITNESS: Yes, sir. One and two are usually combined. Phase three is when the individual has attained that.

Q. Phase three is sometimes in the same clinic as one and two, is it not?

A. It usually is -- and I shouldn't really be speaking for Beth Israel. I would prefer they speak for themselves, but it may be in the samelocation in a general sense, but it may be in a distinct part of that location.

Q Dr. Joseph, in your opinion, when a person is appropriately in a methadone program and properly stabilized, are there any physical deficiencies in their day-to-day conduct, their ability to walk, to think, to see, that sort of thing?

A. No, sir. I mentioned earlier that any one of us sitting in this room could be participating in a phase three or in that properly stabilized clinic.

Q You listed previously some occupations that you knew persons were employed in. I don't think you mentioned specifically the building construction trades. Is that an area where people are employed?

A. _Yes, sir.

Q. Do any patients in your program operate machine tools?

A. Yes, sir. They are tool and die operators in the program.

Q. Punch presses?

A. Yes, punch presses.

Q. have you received any reports of your patients having accidents on the job?

A. No, sir.

Q. Have you received any reports of your patients achieving job promotions?

A. Yes, sir.

Q. How common an occurrence is that in your experience?

A. I guess it's as common as it occurs in any individual not on a methadone program proportionately speaking.

Q. Dr. Joseph, among the persons enrolled in the DACC methadone program, what percentage of them are currently employed? Do you know that figure?

A. I think somewhere in the neighborhood of 80 or a little more.

Q. Does the DACC also run a drug-free program?

A. Yes, sir.

Q Is the employment rate in the drug-free program higher or lower than the employment rate in the methadone program?

A. The most recent figures I have seen as of January were about ten percent lower than in our methadone maintenance program.

MR. BALBER: That concludes or cross, your HOnor.

THE COURT: Thank you very much.

MR. DUNN: I have one question, your Honor.

REDIRECT EXAMINATION

BY MR. DUNN:

Q Is the drug-free program a residential program or is it an ambulatory program?

A. We operate both. We have a residential, a closed ward program. We have residental, open ward programs and we have ambulatory programs.

Q Is part of the reason, Doctor, for the difference in the employment rate for a person on the maintenance free program and a drug-free program the fact that some of the persons on the drug-free program are required to remain in attendance at a hospital or clinic?

A. To the best of my knowledge, they would not be considered in compiling those statistics. It would be in those who are able to go to work. The other group would not be considered.

MR. DUNN: Thank you, Doctor.

THE COURT: Thank you very much.

(Witness excused.)

JUDIANNE DENSEN-GERBER, called as a witness on behalf of the defendant, being first duly sworn, testified as follows:

MR. DUNN: Would you mark this, please.

(Defendant's Exhibit W was marked for identification.)

DIRECT EXAMINATION

BY MR. DUNN:

Q Dr. Densen-Gerber, did you give me or provide for me a curriculum of vitae?

A Yes.

Q Does that accurately reflect your background experience, professional activities?

A Yes, it does.

MR. DUNN: I offer Defendant's Exhibit W.

THE COURT: It is received.

(Defendant's Exhibit W was received in evidence.)

Q Are you actively engaged in the field of rehabilitation of persons who are addicted to narcotic drugs?

A Yes.

Q When did you first enter that field?

A In 1966.

therapy, but I think that is a diagnostic question, not a political or social one which is how it has been used lately.

Q How has it been used politically or socially, Doctor?

A I believe it looked as though the magic pill answer was one which would be quickly available and to give the positive magic bullet theory.

Unfortunately, our major drug abuse across the states is methadone. We have in many jurisdiction more of a methadone problem, illegal and diversionary use of methadone than we have of heroin and of course the death rate is higher in New York now on methadone than it is for heroin.

Q What do you base that on?

A I am married to the Depty Chief Medical Examiner, City of New York who does narcotic autopsies, Dr. Michael Boden.

Q Doctor, in your opinion, would an employer be justified in having reservations with respect to hiring the person who is currently addicted to and using heroin?

A Yes, they would.

Q Would the same be your opinion with respect to a person who has a history of heroin addiction and who is fast.

A In other words, there would have to be a close working relationship between the employer and the clinic to safeguard that the individual was remaining only on the drugs that were presecribed and was taking them on the dose as prescribed every day; that there was no additional illicit drug use and that the individual was taking the same amount of methadone every single day, because if you escalate or deescalate the dose, you have the same phenomenon as you would with heroin.

Q If you could achieve that, what would you feel about the employability of someone on methadone?

A If the individual was on a steady dose of methadone with no ups and downs, then the body becomes tolerant of it and it is as if the person were not taking drugs.

Q Can you go ahead and complete about the employability?

A There would have to be extremely tight controls of the individual on the drug so there would be no opportunity for illicit drug use or for even alcohol use which potentiates the methadone and that this wouldbe the only drug that the individual was taking.

In other words, they couldn't cut itin half, they couldn't sell it, theycouldn't use barbiturates, detoxification. I did run the methadone maintenance unit as I mentioned earlier in my early training. One of our centers is located at 6th Street which is next to a methadone clinic. We have another center located on 53rd Street which is next to a methadone clinic so I see the patients going in and out.

Q The question I am going to ask you now maybe you really can't answer so tell me that, but I am going to ask you, if you could give me an idea or any description to let me know how many of these people you believe exist among the methadone patients who are indeed stabilized in the way that you described earlier?

A I couldn't give you of course a percentage in it. It would be my opinion. I believe most of them under the system with little supportive services in New York and the free dispensing of methadone to almost anyone, makes for just another drug abuse, not a controlled and carefully administered program. Just the sheer numbers in and of itself indicate to me it cannot be used correctly.

Q You say the lack of services?

A The lack of supplenetary supportive services which cause the individual to be able to make slow but steady characterological changes which makes it possible for them not to seek the high and other drugs and alcoholism and barbiturates and the rest of it.

Q Is there a lack of control and testing and urinanalysis?

A Yes, there is.

Q Is this true as of the present time?

A Yes, it is, in this jurisdiction.

Q Is it true despite the existence of the regulations that came out by the Drug Abuse Control Commission in May of 1974?

A Yes, it is.

Q Why is that?

A I think it is part of the New York scene which we tend to be a very permissive society. We tend not to set down rigid rules as a group. We tend to let everybody sort of do their own thing. We have a great tolerance for that. The size of the city makes for that. The fact that one can go from one clinic to another. There are many factors that make methadone control very difficult as compared to Salt Lake or Grand Rapids.

Q Would you distinguish between say the Beth Israel program and other programs which have been described as other programs?

A Yes.

Dr. Dole an Dr. Nyswander do run one of the component of the rehabilitation of any individual.

Q Is there a way, from your view, that an employer like the Transit Authority could hire Methadone patients and determine which one should be hired and which one shouldn't?

A Well --

Q From your viewpoint practical or not.

A I think it's possible. It may not be practical. I think it's possible. I would not put anyone on Methadone or any other drug in a job which was public safety and as I said to Mr. Dunn yesterday if I got on a plane or a train that was driven by someone on any drug I would get off. That is my own feeling and I don't care what all of these muscle studies show.

As my own sense of well being as a citizen I would not want to have my pilot on Methadone. I feel that very strong.

Q I think people are pretty well agreed to that.

A If they cleaned the plane it would not affect me.

Q Aside from the objective thing, we have had testimony from the Transit Authority. There are some non-critical jobs, cleaning jobs, so forth. We won't try to list them. Let's assume we have a man here. You still would want to make a decision whether you want to employ the man.

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